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	495013	A. BUILDING _____ B. WING _____	02/08/2023

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RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD SALEM, VA 24153

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/6/23 through 2/8/23. Corrections are required for compliance with 42 CFR Part 483.73 Requirements for Long Term Care facilities.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		3/22/23

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

Electronically Signed | 03/03/2023

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*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

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E 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, it was determined the facility staff failed to ensure Emergency Preparedness training was documented for one (1) of six (6) employees sampled for Emergency Preparedness training review (Employee F). The findings include: The facility staff was unable to provide the survey team with evidence of Employee F having received Emergency Preparedness training. Employee F was an employee obtained through a staffing agency. On 2/7/23, the surveyor reviewed evidence of the facility staff member's Emergency Preparedness training. No evidence of Emergency	E 037	STEP 1 Employee F will receive Emergency Preparedness Training including the Emergency Operations Plan. STEP 2 Staffing agency personnel have the potential to be affected by this deficient practice. STEP 3 The staffing agencies will be provided a copy of the required training. The expectation will be for the agencies to ensure personnel have completed and attest to understanding of the Emergency Operations Plan prior to starting the	

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E 037	Continued From page 5 Preparedness training was provided to the surveyor for Employee F. On 2/8/23 at 8:42 a.m., the facility's Director of Nursing (DON) reported there was no evidence of Employee F receiving Emergency Preparedness training. The DON reported Employee F was a staff member provided by a staffing agency. On 2/8/23 at 1:10 p.m., the facility's Administrator stated there was no evidence of Employee F receiving Emergency Preparedness training. The Administrator reported Employee F should have been provided Emergency Preparedness training. The following information was found in the facility's Emergency Preparedness documents (with a date of February 2021): "All staff, including individuals providing onsite services under arrangement and volunteers consistent with their expected roles, will be provided initial training in the Emergency Preparedness Program, specifically the Emergency Operations Plan. The facility will test staff competence in their knowledge of the Emergency Preparedness Program through the use of a post training quiz and evaluations during drills and exercise." On 2/8/23 at 3:04 p.m., the survey team met with the facility's Administrator and Director of Nursing. The failure of facility staff to have evidence of Emergency Preparedness training for Employee F was discussed for a final time.	E 037	assignment at Richfield. In the event of emergency staffing and/ or last minute fill in the charge nurse or designee will ensure completion of training prior to the start of the individual's assigned shift. STEP 4 The DON or designee will audit 25% of agency personnel to ensure completion of the Emergency Operation Plan training. The DON/designee will audit 25% of the newly assigned agency staff to ensure completion of the Emergency Plan training weekly x 3 months. Any variances identified will be corrected immediately. The results of the audit will be tracked and trended, and will be reported to QAPI for additional input or guidance. Compliance date 3/22/23	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/06/2023 through 02/08/2023. Corrections are required for	F 000		

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F 000	Continued From page 6 compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 112 certified bed facility was 105 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		3/22/23

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F 584	Continued From page 7 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview and facility policy review the facility failed to ensure a clean, comfortable, and homelike environment as for 3 of 23 Residents (Resident #26, #8, and #50). The findings included: 1. For Resident #26, facility staff failed to clean the wheelchair the resident used when it was visibly soiled. Resident #26 was admitted to the facility with diagnoses that included paranoid schizophrenia, metabolic encephalopathy, dementia, congestive heart failure, pain, osteoarthritis, hypertension, depression, and a history of falls. On the minimum data set assessment with assessment reference date 1/10/2023, the resident scored 1/15 on the brief interview for mental status and was assessed as psychosis or behaviors affecting care. On 2/6/2023 at 2:30 PM, the surveyor interviewed the resident's family member concerning life in	F 584	STEP 1 Resident's #26, #8, and #50's wheelchairs and power chair were cleaned on 2/7/23. On 2/6/23 Resident #26's room and floor was thoroughly cleaned. STEP 2 All residents have the potential to be affected by the deficient practice. Residents with wheel chairs and power chairs have potential to be affected by the deficient practice. STEP 3 A schedule will developed for wheelchairs and power chairs to be lightly cleaned weekly by the homemakers or designee. The wheelchairs and power chairs will be power washed by maintenance	

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F 584	Continued From page 8 the facility. The family member stated that floors and the wheelchair were often dirty. The family member speculated staff appear to clean once per week. The surveyor observed the wheelchair had dried drips on arm and footrests and what looked like splashes on the frame and food in treads. There was also a powder on seat and behind back rest. The floors had some visible dirt and debris. On 2/7/2023 from 10 AM to 1 PM, the surveyor observed the resident in the wheelchair in the common area of the nursing unit. The resident was dressed in clean clothing and appeared well-groomed. The wheelchair had the same stains observed on 2/6/2023. The floors in the room appeared to have the same dirt and debris the surveyor saw the previous day. On 2/7/2023, the surveyor reported the concern with the cleanliness of the room and wheelchair during a summary meeting that included surveyors and the administrator and director of nursing. The facility policy titled Cleaning and Disinfection of Wheelchairs/Power chairs dated January 2021 under Policy /Procedure states: 1. Staff are to monitor the cleanliness of resident's wheelchairs/powerchairs. Staff are to ensure they clean wheelchairs twice a year and as needed if a wheelchair/power chair becomes dirty. On 2/8/2023, the resident's floor was clean. Physical therapy staff had assessed the resident's positioning in the chair and replaced the chair with one that better fit the resident's	F 584	or designee twice per year and as needed when soiled deeply. The resident room floors will be cleaned on a daily basis by housekeeping or designee. The staff will be reeducated on the cleaning processes. STEP 4 The administrator or designee will audit the cleanliness of 25% of the wheelchairs or power chairs weekly X 3 months any discrepancies noted will be corrected immediately. The administrator or designee will audit the cleanliness of 25% of the resident room floor weekly x 3 months, any discrepancies noted will be corrected immediately. The results of the audits will be tracked and trended presented to QAPI for additional guidance and input. Compliance Date 3/22/23	

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needs.
2. For resident #8 the facility failed to maintain a clean and sanitary wheelchair.

Resident #8's diagnosis list includes but is not limited to, dementia, dysphagia, heart failure, hypertension and chronic obstructive pulmonary disease.

Resident #8's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/23 indicates under Section C., Cognitive Patterns, that resident is rarely to never understood, that they have impaired long and short-term memory, and decision making is severely impaired. In Section G., Functional Status, the resident is coded as needing extensive physical assistance of one person for personal hygiene.

On 2/6/23 at 3:11 P.M. Surveyor observed resident lying in her bed with wheelchair at bedside. Wheelchair was dirty, heavily soiled with food particles and other debris on the footrests, frame, support bars, seat cushion, and back support had dried brown matter smeared on it.

2/7/23 at 9:10 A.M. Surveyor observed resident still in bed. Wheelchair was dirty with food particles caked on frame and foot pedals as well as brown material on the back rest of the chair.

2/7/23 2:56 P.M. Surveyor asked the Director of Nursing (DON) to look at resident #8's chair. Resident was up in the chair seated in the day room. Chair remained heavily soiled with debris. Surveyor requested the policy for wheelchair cleaning. DON stated that chairs are cleaned on an as needed basis.

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2/7/23 4:05 P.M. during the end of day meeting with the Administrator and DON, surveyor reviewed concerns with wheelchairs. Surveyor asked for a policy for cleaning wheelchairs and DON stated that the wheelchairs are already clean, "I let them know how nasty they were, and they are already clean".

Chair observed to be clean 2/8/23 at 8:05 A.M.

2/8/23 at 8:08 A.M. surveyor interviewed C.N.A.#3 about the process for cleaning chairs, they replied, " Let me check and get back to you".

2/8/23 8:16:23 Surveyor Interviewed Licensed Practical Nurse (L.P.N.) #2, about the policy for cleaning wheelchairs. They stated, "usually, I'm not 100% sure, but it's done on night shift because residents don't need their chairs at night. I'm not sure of the schedule or anything".

2/8/23 9:45 A.M. Surveyor received a copy of the policy entitled, "Cleaning and Disinfecting of Wheelchairs/Power Chairs" with an effective date of 1/21/23, which read in part, "Staff are to monitor the cleanliness of resident's wheelchairs/power chairs. Staff are to ensure they clean wheelchairs twice a year and as needed if a wheelchair/power chair becomes dirty".

2/8/23 at 3:05 P.M. during end of day meeting surveyor again reviewed concerns regarding resident's wheelchair with DON and Administrator. No further information was received prior to exit.

3. For resident #50 the facility failed to maintain a

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clean and sanitary power chair.

Resident #50's diagnosis list includes but is not limited to, Cerebral Vascular Accident (CVA) with right sided hemiplegia, anxiety, depression, hypertension, and anemia.

Resident #50's annual MDS with an ARD of 11/3022 is coded under Section C., Cognitive Patterns a BIMS score of 15 indicating resident is cognitively intact. In Section G., Functional Status resident is coded as 8/8 for walking meaning this activity did not occur, and under locomotion on and off the unit, resident is coded as independent.

On 2/6/23 at 2:45 P.M. and during initial tour, surveyor observed resident #50 sitting in power chair that was soiled with dust, and food debris that was caked on bilateral foot pedals. Surveyor asked resident if they knew how often chair was cleaned and they stated, "twice a year". Surveyor asked if it had been a while since the last time and they stated that it had, and "I can't even remember when the last time was".

2/7/23 2:56 P.M. Surveyor asked the Director of Nursing (DON) to look at resident #50's chair. Resident was up in the chair seated in the day room. Chair remained soiled with debris. Surveyor requested the policy for wheelchair cleaning. DON stated that chairs are cleaned on an as needed basis.

2/7/23 4:05 P.M. during the end of day meeting with the Administrator and DON, surveyor reviewed concerns with resident #50's power chair. Surveyor asked for a policy for cleaning wheelchairs and DON stated that the wheelchairs

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F 584	Continued From page 12 are already clean, "I let them know how nasty they were, and they are already clean". Chair observed to be clean 2/8/23 at 8:05 A.M. 2/8/23 at 8:08 A.M. surveyor interviewed C.N.A.#3 about the process for cleaning chairs, they replied, " Let me check and get back to you". 2/8/23 8:16:23 Surveyor Interviewed Licensed Practical Nurse (L.P.N.) #2, about the policy for cleaning wheelchairs/power chairs. They stated, "usually, I'm not 100% sure, but it's done on night shift because residents don't need their chairs at night. I'm not sure of the schedule or anything". 2/8/23 9:45 A.M. Surveyor received a copy of the policy entitled, "Cleaning and Disinfecting of Wheelchairs/Power Chairs" with an effective date of 1/21/23, which read in part, "Staff are to monitor the cleanliness of resident's wheelchairs/power chairs. Staff are to ensure they clean wheelchairs twice a year and as needed if a wheelchair/power chair becomes dirty". 2/8/23 at 3:05 P.M. during end of day meeting surveyor again reviewed concerns regarding resident's wheelchair with DON and Administrator. No further information was received prior to exit.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,	F 607		3/22/23

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F 607	Continued From page 13 neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review, and facility document review, the facility staff failed to follow their policy and procedure in regard to screening of new hires for 9 of 25 new hires. The findings included: The facility staff failed to obtain reference checks on new hire #1, #2, #3, #6, #7, #9, #10, #16, and #17 and failed to obtain background checks on new hire #3 and #9 until 02/07/23.	F 607	STEP 1 Staff member #3's and #9's background checks were completed on 2/7/22, no issue was identified on either background check. HR or designee will attempt to obtain reference checks on staff members, #1, #2, #3, #6, #7, #9, #10, #16 and #17. In the event of negative reference, a referral will be sent to the	

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F 607	Continued From page 14 02/07/23, the survey team requested employee files from the facility. 02/08/23, the surveyor reviewed 25 new hire records (employee records). New hire #1, #2, #3, #6, #7, #9, #10, #16, and #17 employee records did not include reference checks. For new hires #3 and #9 background checks were not completed until 02/07/23. New hire #3's date of employment was documented as 11/14/22 and #9's was documented as 08/15/22. A review of the results obtained on 02/07/23 indicated there was no issue with either employees background check. On 02/08/23, the facility staff provided the surveyor with a copy of a document titled, Hiring Process. This document read in part, "...All candidates for employment and any new positions should proceed through the hiring process according to these guidelines...Human Resources...Perform Background checks and Reference check...Unsatisfactory results of the background check, references...should be discussed with the Administrator..." 02/08/23 11:05 a.m., Human Resource employee (HR) #1 stated reference checks were not completed on all new hires. 02/08/23 11:20 a.m., HR #1 stated the employees that would have completed the employee files were no longer employed at the facility and they had obtained new hire's #3 and #9's criminal background checks on 02/07/23.	F 607	Administrator and Corp. HR for review. STEP 2 All new hired employees have the potential to be affected by the deficient practice. STEP 3 The HR staff will be educated on the importance of obtaining background checks and reference checks per the facility policy on newly hired employees. STEP 4 Corporate HR or designee will audit 25% of new hired employee files to ensure background checks and reference checks were completed, prior to the start of their first assigned shift. The audits will be completed monthly x 3 months. And discrepancies noted will be corrected immediately. The audits will be tracked and trended and presented to QAPI for additional guidance and input. Compliance Date 3/22/23	

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F 607	Continued From page 15 02/08/23 12:25 p.m., the Administrator and Director of Nursing (DON) were made aware of the issues regarding the employee files. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 607		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		3/22/23

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F 657	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review the facility staff failed to review and revise the comprehensive care plan for 2 of 26 residents, Resident #38 and Resident #83. The findings included: 1. For Resident #38 the facility staff failed to revise the care plan for COVID status. Resident #38's face sheet listed diagnoses which included but not limited to aphasia, type 2 diabetes mellitus, hypertension, depression and dementia. Resident #38's most recent minimum data set with an assessment reference date of 01/05/23 assigned the resident a brief interview for mental status score of 13 out of 15 in section C, cognitive patterns. This indicates the resident is cognitively intact. Resident #38's comprehensive care plan was reviewed and contained a care plan for " ... (Resident #38) is positive for COVID-19" This care plan was initiated on 12/29/2022. Goals for this care plan included "... care and symptoms will be managed per CDC (Centers for Disease Control) guidelines and facility protocol" This goal has a revision date of 01/31/2023. Resident #38's clinical record was reviewed and contained a physician's order summary which read in part "Remain on droplet isolation every shift for monitoring for 5 days-start date 12/29/2022, end date-01/03/2023" and Remain droplet isolation every shift for monitoring until	F 657	STEP 1 Resident #38's care plan was updated for her COVID and isolation status. Resident #83 is no longer a resident at Richfield. STEP 2 Residents that have recovered from COVID or have a deep tissue injury have the potential to be affected by the deficient practice. STEP 3 Licensed clinical staff will be re-educated on updating comprehensive care plans when residents recover from COVID and/or upon the discovery of deep tissue injuries. STEP 4 The DON or designee will audit the comprehensive care plans of residents that have recovered from COVID and/or have a deep tissue injury discovered. The DON or designee will ensure the care plans are updated with current status and resident specific information. The audits will be weekly x 3 months, any discrepancies noted will be corrected immediately. The results of the audit will be tracked and trended and presented to	

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F 657	Continued From page 17 01/09/2023-start date 01/02/2023, end date-01/09/2023" Surveyor observed Resident #38 on 02/06/23 at 2:20 pm. Resident was resting on bed with eyes closed. There was no signage indicating resident was on any type of contact precautions. Surveyor observed Resident #38 on 02/07/23 at 8:30 am. Resident was resting on bed. Surveyor asked resident is they had COVID-19, and resident replied that they did not, but had had it in the past. Surveyor spoke with the director of nursing (DON) on 02/08/23 at 8:50 am. Surveyor asked DON how often care plans were updated and DON stated that anytime there was a change in resident's status the care plan should be updated to reflect the change. Surveyor pointed out that Resident #38 was care planned for being COVID positive, and DON stated that should have been resolved and that they would take care of it immediately. DON provided surveyor with an updated care plan on 02/08/23 at 9:15 am. The concern on not revising Resident #38's care plan to reflect current status was discussed with the administrator and DON on 02/28/23 at 3:05 pm. No further information was provided prior to exit. 2. For Resident #83, the facility staff failed to revise the comprehensive person-centered plan of care following discovery of a deep tissue injury (DTI) to the right heel. Resident #83's diagnosis list indicated diagnoses, which included, but not limited to fracture of	F 657	QAPI for additional guidance and input. Compliance date 3/22/23	

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T9-T10 Vertebra, Paroxysmal Atrial Fibrillation, Neuromuscular Dysfunction of Bladder, Hypertensive Heart Disease, Chronic Kidney Disease, and Pneumonia.

The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 1/10/23 assigned the resident a brief interview for mental status (BIMS) summary score of 0 out of 15 indicating Resident #83 was severely cognitively impaired.

A review of Resident #83's clinical record revealed a physician's order dated 2/03/23 to apply Betadine every day and evening shift to the left and right heels. Surveyor reviewed the resident's current comprehensive person-centered plan of care and was unable to locate documentation of any treatment needs to the right heel.

On 2/07/23 at approximately 2:05 pm, surveyor spoke with the director of nursing (DON) regarding Resident #83's right heel. The DON stated the area to the right heel was acquired and discovered on the day of the treatment order, 2/03/23.

Resident #83's clinical record included a late entry nursing progress note dated 2/07/23 for 2/03/23 stating in part "Nurse came to writer stated that she noted a skin area to patients lateral right heel, after assessing area writer noted 1 x 1 DTI [deep tissue injury] area to lateral right heel. NP [nurse practitioner] and RP [responsible party] made aware and new order placed for betadine and applied'.

On 2/08/23 at 1:28 pm, surveyor spoke with the

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F 657	Continued From page 19 MDS Coordinator who stated the area to Resident #83's right heel was new and should have been care planned on 2/03/23 and they are providing education to the nurses to update the plan of care when initiating treatment. Surveyor requested and received the facility policy entitled, "Care Plans, Comprehensive Person-Centered" which read in part " ...14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition ..." On 2/08/23 at 3:04 pm, surveyor met with the administrator and DON and discussed the concern of staff failing to revise Resident #83's comprehensive care plan to include a DTI to the right heel. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/08/23.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility policy review, the facility staff failed to provide activity of daily living (ADL) care for 4 of 23 current Residents, Residents #3, #4, #8, and #60. The findings included:	F 677	STEP 1 Residents #3's #4's 8's and 60's nail were cleaned, trimmed and filed on 2/8. STEP 2 All residents have the potential to be affected by the deficient practice.	3/22/23

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F 677	Continued From page 20 1. For Resident #3, the facility staff failed to provide nail care. Resident #3's fingernails were observed to be long. Resident #3's diagnoses included, but were not limited to, cerebral palsy, diabetes, and apraxia. Section C (cognitive patterns) of Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/04/22 included a brief interview for mental status (BIMS) summary score of 15. Section G (functional status) was coded 3/2 for personal hygiene to indicate they required extensive assistance of one person for this task. Resident #3's comprehensive care plan included the focus area has self-care deficits in ADL performance due to decreased mobility, unsteady balance, and communication. Interventions included, but were not limited to, check nail length and trim and clean on bath day and as necessary. 02/07/23, during initial tour of the facility Resident #3 was observed to be up in their wheelchair. Their fingernails were observed to be long. 02/07/23 09:20 a.m., Resident #3's nails were observed to be long. When asked if they liked their nails this length Resident #3 shook their head, no. 02/07/23 10:44 a.m., the Director of Nursing (DON) was made aware of the issues regarding Resident #3's nails. The facility staff provided the survey team with a copy of their policy titled, "Fingernails/Toenails,	F 677	STEP 3 The clinical staff will be re-educated on providing nail care to residents on their assigned shower days. STEP 4 The DON or designee will audit 25% of residents weekly x 3 months to ensure their nails are clean, trimmed and filed. Any discrepancies noted will be corrected immediately. The audits will be track and trended and results reported to QAPI for additional guidance and input. Compliance date 3/22/23	

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Care of" effective date January 2021. This policy read in part, "...The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections...Nail care includes a cleaning and regular trimming as needed or desired by resident..."

02/07/23 4:00 p.m., during and end of the day meeting with the Administrator and DON the issue regarding Resident #3's fingernails was reviewed.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #4, the facility staff failed to provide nail care. Resident #4's nails were observed to be long, jagged with debris present.

Resident #4's diagnoses included, but were not limited to, cognitive communication deficit, aphasia, and muscle weakness.

Section C (cognitive patterns) of Resident #4's admission minimum data set (MDS) with an assessment reference date (ARD) 01/08/23 included a brief interview for mental status (BIMS) summary score of 13 out of a possible 15 points.

Resident #4's comprehensive care plan included the focus area has potential for decline in activity of daily living (ADL) capabilities.

02/06/23 2:30 p.m., Resident #4's fingernails were observed to be long, jagged, with debris present. Resident #4 stated they needed to be cut.

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02/07/23 9:25 a.m., certified nursing assistant (CNA) #1 in room. Resident #4's bilateral fingernails were observed to be long, jagged, with debris present. CNA #1 stated they were going to cut Resident #4's nails.

02/07/23 10:44 a.m., the Director of Nursing (DON) was made aware of the issues regarding Resident #4's nails.

The facility staff provided the survey team with a copy of their policy titled, "Fingernails/Toenails, Care of" effective date January 2021. This policy read in part, "...The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections...Nail care includes a cleaning and regular trimming as needed or desired by resident..."

02/07/23 4:00 p.m., during and end of the day meeting with the Administrator and DON the issue regarding Resident #4's fingernails was reviewed.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #8, the facility staff failed to provide nail care.

Resident #8's listed diagnoses included, but were not limited to, dementia, dysphagia, heart failure, hypertension and chronic obstructive pulmonary disease.

Resident #8's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/23 indicates under Section C.,

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Cognitive Patterns, that resident is rarely to never understood, that they have impaired long and short-term memory, and decision making is severely impaired. In Section G., Functional Status, the resident is coded as needing extensive physical assistance of one person for personal hygiene. Under Section E. Behavior, there were no instances of care refusals coded.

On 2/6/23 at 2:30 P.M. During the initial tour, surveyor met observed resident #8 and noted that their fingernails were long and jagged with debris underneath. Resident was nonverbal and unable to answer surveyor questions regarding nail care.

On 2/7/23 at 9:10 A.M. Surveyor again noted that resident #8's nails were long, jagged and had yellow and brown debris caked under them. Surveyor interviewed C.N.A. #3 at this time. When asked about how often nail care is provided to resident's they stated, "We do manicures once a week but some residents refuse". When asked about resident #8, C.N.A. #3 stated that resident is one who refuses. Surveyor asked where this would be documented and they replied, "In the care plan".

On 2/7/23 at 9:15 A.M. surveyor interviewed Certified Nursing Assistant (C.N.A.) #2 who was in resident #8's room and stated they were just finishing her morning care. When asked if resident refuses care such as nail care, they stated, "No, not really" and then stated resident is usually "Just stiff".

2/7/23 at 2:30 P.M. Observed resident #8 sitting in the day room eating popcorn, nails remained long, jagged and with debris underneath.

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2/7/23 2:56 P.M. surveyor met with the Director of Nursing (DON) and asked them to look at resident #8's fingernails. DON stated that resident can be resistive to care at times. Surveyor asked if that would be included in the resident's care plan and DON stated it would be. Surveyor requested the policy regarding nail care, face sheet, care plan and MDS.
Surveyor reviewed resident #8's care plan at 3:00 P.M. on 2/7/23 and was unable to locate a focus, goal or intervention addressing care refusals.

End of day meeting 2/7/23 4:05 P.M. Surveyor reviewed concerns regarding nail care with DON and Administrator.

2/8/23 8:18 A.M. Resident observed by surveyor sitting in the day room. Nails were clean and trimmed.

2/8/23 at 9:45 A.M. DON brought surveyor documents that included the residents care plan. Surveyor noted that there was an activity care plan with a goal statement that read, "_____ needs a lot of encouragement during nail care most of the time they will refuse due to agitation". The care plan included a revision date of 2/7/23. Documents also included a nurse's progress note date 2/7/23 10:00 A.M. that read, C.N.A. #3 "attempted to trim resident nails at this time, resident started pulling hand back and stating no no. Nail care was stopped at this time due to resident not wanting nail care at this time". A second progress note dated 2/7/23 at 5:33 P.M. read in part, " ... the resident gets anxious when nails are trimmed. The household coordinator was keeping resident occupied by talking and this nurse cut nails". "This nurse was able to cut all nails with minimal distress".

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F 677	Continued From page 25	F 677		

2/8/23 at 12:00 P.M. Surveyor asked DON to clarify if the care plan had been revised for nail care refusals on 2/7/23 and she stated that it had been.

2/8/23 at 3:05 P.M. during end of day meeting surveyor again reviewed concerns regarding nail care with DON and Administrator. no further information was received prior to exit.

4. For Resident #60 the facility staff failed to provide nail care.

Resident #60's face sheet listed diagnoses which included but not limited dementia, peripheral vascular disease, type 2 diabetes, and hypertension.

The most recent minimum data set with an assessment reference date of 12/27/22 assigned the resident a brief interview for mental status score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section G, functional status, coded the resident as needing extensive assistance of two-person physical assist in personal hygiene.

Resident #60's comprehensive care plan was reviewed and contained a care plan for "Potential for decline in ADL (activities of daily living) capabilities"

Surveyor observed Resident #60 on 02/07/23 at 8:25 am. Resident was sitting up in bed, eating breakfast. Surveyor observed that resident's fingernails were long and jagged, with brownish

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F 677	Continued From page 26 discoloration. Surveyor was provided with a facility policy entitled "Fingernails/Toenails, Care of", which read in part "1. Nail care includes cleaning and regular trimming as needed or desired by resident" Surveyor spoke with director of nursing (DON) on 02/08/23 at 9:15 am, and informed them of Resident #60's nails being long, and DON stated that a 100% audit of resident nails had been completed. The concern of Resident #60's nails being long and jagged was discussed with the administrator and DON on 02/08/23 at 3:05 pm. No further information was provided prior to exit.	F 677		
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 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		3/22/23

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F 757	Continued From page 27 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, and clinical record review the facility staff failed to ensure 1 of 23 residents was free of unnecessary medications (Resident #26). The findings included: Resident #26 was admitted to the facility with diagnoses that included paranoid schizophrenia, metabolic encephalopathy, dementia, congestive heart failure, pain, osteoarthritis, hypertension, depression, and a history of falls. On the minimum data set assessment with assessment reference date 1/10/2023, the resident scored 1/15 on the brief interview for mental status and was assessed as psychosis or behaviors affecting care. The resident weighed 79 pounds. Resident #26 was chosen for medication regimen review. During clinical record review on 2/08/2023, the surveyor found monthly pharmacy reviews were conducted from admission. The recommendation dated 8/17/2022 contained several suggestions including: 5) remains on iron 325 mg every 48 hours for supplement. Non coated iron is very likely to cause GI disturbance /constipation/GI pain. Consider using Slow-FE as this is more gentle on the GI system. The family nurse practitioner (FNP) wrote "change to Slow-FE of comparable dose" on 8/18/2022.	F 757	STEP 1 Resident #26's iron orders were corrected on 12/28/22 to Slow-Fe daily and the regular iron was discontinued. STEP 2 Resident's receiving iron medications have the potential to be affected by the deficient practice. STEP 3 The Clinical Coordinators and licensed nursing staff will be re-educated on the pharmacy drug regimen review and recommendations process. The pharmacy will provide the DON the recommendations following drug regimen reviews. The DON will the forward the recommendations to the Clinical Coordinators to ensure the recommendations are communicated to the providers. The providers will then accept, modify or decline the recommendations. The nursing staff will ensure the provider orders are	

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F 757	Continued From page 28 The October 2022 medication administration record (MAR) showed staff started administering Slow-FE Extended Release 142 (45 Fe) MG Ferrous Sulfate ER) Give 1 tablet by mouth every 48 hours for Supplement every other day on 8/19/22. Staff continued administering Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet by mouth every 48 hours for Supplement. The resident then received iron supplements daily instead of every 48 hours from October 19/2022 through 2/8/23. A pharmacy recommendation dated 12/23/2022 stated "Mid November [resident #26] started on alternating orders-Slow-Fe alternating days with regular iron 325 mg. As this is fairly atypical/ patients usually take one or the other just for simplicity and the Slow-Fe is kinder on the GI tract, consider using only one of these or note that it is appropriate as is." The FNP (not the one who wrote the 8/18/22 recommendation) accepted the recommendation on 12/29/22 and wrote an order to change to current dose of Slow-Fe daily and discontinue regular iron. The resident received Slow-Fe daily from 12/29 through the survey date of 2/8/2022. During a summary meeting on 2/8/2022 which included the administrator and director of nursing, the surveyor notified staff of the concern that the pharmacy recommendation was to replace the iron order with Slow FE rather than add another dose and that the physician and nurse practitioner had not intended to continue the order for regular iron when the order for Slow-Fe was written and that the physician and nurse practitioner had not intended to double the dose of iron the resident received.	F 757	implemented correctly. The Clinical Coordinators will then ensure the recommendations have been addressed by the providers and provide the information to the DON. STEP 4 During the monthly drug regimen review, the pharmacist or designee will audit the previous month's recommendations to ensure the provider has addressed the recommendations x 3 months. The pharmacist or designee will address with the provider any noted discrepancies. The audits will be tracked and trended and results will be reported in QAPI for additional follow up and input. Compliance date 3/22/23	

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F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide laboratory services to meet the needs of the resident for 1 of 23 residents in the survey sample, Resident #83. The findings included: For Resident #83, the facility staff failed to obtain a urinalysis with reflex and a complete blood count (CBC) lab test as ordered by the physician on 2/04/23. Resident #83's diagnosis list indicated diagnoses, which included, but not limited to fracture of T9-T10 Vertebra, Paroxysmal Atrial Fibrillation, Neuromuscular Dysfunction of Bladder, Hypertensive Heart Disease, Chronic Kidney Disease, and Pneumonia. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 1/10/23 assigned the resident a brief interview for mental status (BIMS) summary score of 0 out of 15 indicating Resident #83 was severely cognitively impaired.	F 770	STEP 1 The physician and resident representative were notified on 2/7/23 that Resident #83's lab orders from 2/4/23 were missed. Discussion with the resident representative and physician reveal the labs were no longer necessary as the resident was placed under hospice services on 2/6/22. STEP 2 Residents with lab orders have potential to be affected by the deficient practice. STEP 3 The clinical staff will be re-educated on the lab process. The education will reiterate that lab draws are not to be scheduled on Sundays. STEP 4 The DON or designee will audit 25% of	3/22/23

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F 770	Continued From page 30 A review of Resident #83's clinical record revealed physician's orders dated 2/04/23 for a urinalysis with reflex and a CBC lab test; surveyor was unable to locate results for lab tests. On 2/07/23 at 2:04 pm, surveyor spoke with the director of nursing (DON) regarding the lab tests. The DON stated the labs were missed over the weekend and it was an oversight. The DON further stated staff have discussed the missed labs with the physician and family and both agreed that the labs were no longer needed as the resident went on hospice care yesterday. Resident #83's clinical record included a nursing progress note dated 2/07/23 at 1:31 pm stating in part "Dr. [name omitted] made aware of missed labs over weekend. Patient is now hospice and family does not wish to have these labs repeated". Surveyor requested and received the facility policy entitled "Lab and Diagnostic Test Results - Clinical Protocol" which read in part "Purpose 1. The physician/practitioner will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests ..." On 2/08/23 at 3:04 pm, surveyor met with the administrator and DON and discussed the concern of staff failing to obtain the physician ordered urinalysis and CBC for Resident #83. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/08/23.	F 770	the lab orders weekly x 3 months to ensure labs have been obtained and process per provider orders. Any discrepancies noted will be corrected immediately. The audit will be tracked and trended and results provided to QAPI for additional input or guidance. Compliance date 3/22/23	

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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 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/22/23

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F 880	Continued From page 32 (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 observations, staff interviews, and facility document review, the facility staff failed to maintain an infection control and prevention program that ensured a sanitary laundry environment to decrease infection control risk for one (1) of five (5) residential laundry rooms. The findings include: On 2/8/23 at 10:30 a.m., one (1) of the facility laundry rooms (used to wash resident clothing)	F 880	STEP 1 The bag of soiled personal laundry was washed and clothing returned to the residents STEP 2 The residents residing on The Rehab Unit have the potential to be affected by the deficient practice. STEP 3 The residents and resident	

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F 880	Continued From page 33 was observed with the facility's Administrator. A plastic bag containing soiled laundry was observed on the top of one (1) of the washing machines. The Administrator confirmed the aforementioned laundry needed to be washed. The following information was found in a facility document with the subject of "Resident Laundry" (with an effective date of January 2021): "Laundry Room ... To remain in an orderly fashion and no dirty linen to be stored on the equipment". On 2/8/23 at 1:10 p.m., the facility's Administrator stated soiled laundry should be kept in a resident's room until it is ready to go into the washing machine. The Administrator reported the soiled laundry should not have been placed on the top of the washer. On 2/8/23 at 3:04 p.m., the survey team met with the facility's Administrator and Director of Nursing. The placement of a plastic bag containing soiled laundry on top of a washing machine in the residential laundry room was discussed for a final time.	F 880	representatives on The Rehab unit will be reminded of the facility policy that the "a laundry room is available for your convenience, free of charge. Complimentary detergent and dryer sheets are available. Simply ask a team member for assistance." They will also be reminded that soiled clothing should not be placed in the laundry room. The admission team will be re-educated on the laundry room policy and practices so they can alert new residents on the practice. STEP 4 The Housekeeping Director or designee will round on the laundry room on The Rehab Unit 3 times per week X 3 months to ensure soiled laundry is not being placed in the laundry room. Any variances noted will be corrected immediately. The audits will be tracked and trended and results presented in QAPI for guidance and input. Compliance date 3/22/23	