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

PRINTED: 05/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495333		04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/24/23 through 04/26/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 4/24/23 through 4/26/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 132 certified bed facility was 124 at the time of the survey. The survey sample consisted of 26 current resident reviews and 4 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.	F 584	F-584 1. Shower room on C wing of the facility was cleaned and cabinet lock was locked during the time of survey. 2. All Shower room in the facility were checked for cleanliness and the cabinet doors were locked. 3. All Housekeeping and Nursing Staff will be educated on providing Safe/Clean/Comfortable/ Home like environment to include clean shower room and locked cabinet doors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/12/2023

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 584	Continued From page 1 (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 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, staff interview, and resident interview the facility staff failed to ensure a clean, comfortable, homelike environment for 1 of 4 shower rooms in the facility. The findings included: For the shower room on C-wing of the facility, there was an odor of urine and mildew, a cabinet	F 584	4. QA tool will be completed 3x week for 8 weeks to assure shower rooms are safe/clean. These results will be reviewed and discussed by the interdisciplinary team through the QA process and corrective action plans put into place as indicated based on review, along with determinations and related to ongoing monitoring. 5. Date of compliance: 6/2/23	

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F 584	Continued From page 2 labeled "Keep cabinet locked at all times!!!" was found unlocked, shampoo and body wash were lying on the shower stretcher, and a shoe was lying in the bathroom floor. On 04/24/23 at 3:15 pm, surveyor interviewed Resident #62. Resident #62 stated to surveyor that the shower room on C-wing was dirty and "smells like mildew". Resident #62's most recent minimum data set with an assessment reference date of 03/10/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Surveyor observed the shower room on C-wing on 04/25/23 at 1:35 pm. Surveyor noted a strong odor of urine in the shower room at this time. Surveyor observed the shower room on C-wing on 04/26/23 at 8:30 am. Surveyor noted an odor of mildew in the area, a used pair of gloves lying in the floor, a bottle of shampoo and a bottle of body wash lying on a shower stretcher, a shoe in the bathroom floor, and an unlocked cabinet containing toiletry items labeled "Keep cabinet locked at all times." Surveyor, along with director of nursing (DON), observed shower room on 04/26/23 at 8:40 am. DON stated it should not look this way, and immediately asked a staff member to clean the area. The concern of the not providing a clean, comfortable environment was discussed with the administrator, DON, and assistant director of nursing on 04/26/23 at 4:15 pm.	F 584		

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F 584	Continued From page 3 No further information provided prior to exit.	F 584		
F 656 SS=D	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 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	F 656	F-656 1. Resident #376 care plan has been updated to reflect altered skin integrity and wound care. Resident #376 MDS modified to include venous/arterial ulcer. 2. All residents with altered skin integrity were checked to ensure care plan and MDS are correct. 3. Licensed nursing staff and MDS will be educated to ensure altered skin integrity is documented on MDS and care plan. 4. QA tool will be completed weekly x 8 weeks to ensure altered skin integrity are on care plan and MDS. These results will be reviewed and discussed by the Interdisciplinary Team through the QA process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 6/2/23	

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F 656	Continued From page 4 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 observation, staff interview, resident interview, clinical record review, and facility document review, the facility staff failed to develop and implement a comprehensive person-centered care plan to meet the needs of the resident for 1 of 26 residents in the survey sample. The findings include: For resident #376, the facility staff failed to develop a care plan to address pressure ulcer risk and wound care. Resident #376 diagnoses included, but were not limited to, congested heart failure, chronic obstructive pulmonary disease, cellulitis of the left lower limb, atrial fibrillation, pneumonia and malnutrition. The admission Minimum Date Set Assessment (MDS), with an Assessment Reference Date (ARD) of 4/12/23 assigned the resident a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating that resident #376 was cognitively intact. Resident #376 was coded	F 656		

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F 656	Continued From page 5 in section G of the MDS as requiring extensive assistance of one or two people with bed mobility, transfers, toileting and personal hygiene. In section H of the MDS, resident #376 was coded as being occasionally incontinent of urine and mostly incontinent of bowel. Under section M of the MDS, the resident was coded as being at risk for developing pressure ulcers and was coded as requiring daily application of non-surgical dressings. There were no pressure ulcers or venous/arterial ulcers coded. A review of resident #376's orders revealed the following entered on 4/7/2023, "Cleanse sacrum with facility approved wound cleanser, cover with hydrofera blue and mepliex everyday and PRN" (as needed), and another entered on 4/10/23, "Cleanse abrasion to LLE (left lower extremity) with wound cleanser, pat dry. Apply honey fiber. Cover with a foam dressing every day shift Monday, Wednesday and Friday for wound care". The treatment administration record (TAR) was reviewed, and facility staff had been signing off on these orders daily indicating that the orders were being carried out. On 4/26/23 at 9:50 AM, surveyor interviewed resident #376 to inquire about the wound on her sacrum. Resident informed surveyor that there was no wound on her sacrum. Resident denied any wound care being performed on her sacrum. Resident stated that she had a wound on her left leg that the nurses were treating but no others on her body. On 4/26/23 surveyor reviewed resident #376's comprehensive care plan. Surveyor was unable to locate a care plan for wound care or for resident being at risk for pressure ulcers.	F 656		

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F 656	Continued From page 6 Surveyor interviewed LPN #1 on 4/26/23 at 10:00 AM. Surveyor asked if a resident who gets daily wound care should have a care plan for wound/skin care. LPN stated, "yes, they should". Surveyor asked LPN #1 to look at resident #376's orders and asked if they could locate a care plan for the wound care being provided, they stated, "I don't see one". When asked about the process for care planning wounds, LPN #1 stated that the wound nurse typically added wounds to the care plan. On 4/26/23 at 12:40 PM, surveyor interviewed the wound nurse LPN # 9. When asked who care plans wounds, they stated, "I do if it's a wound I follow". When asked if Resident #376 should have a care plan for wound care they stated, "yes, but it's not pressure so I don't do those". Surveyor asked if pressure ulcers were the only wounds that should be care planned and LPN #9 stated that they would not care plan all wound care. On 4/26/23 at 12:45 PM surveyor interviewed the Assistant Director of Nursing (ADON) and asked if they would expect a resident getting routine wound care to have a care plan for wound care and they stated, "Yes, I would". On 4/26/23 at 2:24 PM surveyor interviewed RN #1 about resident being at risk for pressure ulcers and not having a skin or wound care plan. RN #1 stated that they would initiate care plans based on the MDS assessment but that resident #376's admission assessment had not yet been complete so they would not have care planned anything yet. On 4/26/23 at 2:43 PM RN #1 returned to surveyor and stated that they were	F 656		

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F 656	Continued From page 7 mistaken and that the admission MDS had already been completed. Surveyor requested and received the policy entitled, "Care Planning- Interdisciplinary Team". The policy stated in part, "Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident", and "A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment" (MDS). The policy went on to say, "the care plan is based on the resident's comprehensive assessment". On 4/26/23 at 4:17 PM the survey team met with the Administrator and Director of Nursing; they were informed of this concern. No further information was provided to the survey team prior to the exit conference.	F 656		
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, resident interview, clinical record review and facility document review the facility staff failed to follow professional standards of practice for physician notifications and documentation of medications and/or treatments for 2 of 26 residents, Resident #99, and Resident #376.	F 658	F-658 1. Provider notified of resident #99 insulin refusals on 3/14/23, 3/23/23, 3/25/23, 3/26/23, 4/1/23 and doses not given on 3/2/23,3/4/23 and 4/2/23. Treatment was discontinued to sacrum on resident #376 due to no wound being present. 2. All current residents with insulin refusal will have Provider notification. 3. All nurses will be educated to notify the Provider of all insulin refusals/ omissions and resolved wounds to discontinue treatment orders.	

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F 658	Continued From page 8 The findings included: 1. For Resident #99 the facility staff failed to notify the physician and document medication refusals in the clinical record. Resident #99's face sheet listed diagnoses which included but not limited to type II diabetes mellitus. The most recent minimum data set with an assessment reference date of 03/01/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive status. This indicates that the resident is cognitively intact. Resident #99's comprehensive care plan was reviewed and contained a care plan for "the resident has Diabetes Mellitus." Interventions for this care plan included "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness." Resident #99's clinical record was reviewed and contained a physician's order summary which read in part, "Semglee solution 100 unit/ml (Insulin glargine). Inject 18 units subcutaneously at bedtime for DM (diabetes mellitus)." Resident #99's electronic medication administration records (eMAR) for the months of March and April 2023 were reviewed and contained entries as above. The eMAR was coded "2" on 03/02/23, 03/04/23 and 03/10/23 for the insulin administration. There is no equivalent for chart code "2". The eMAR was coded "9" on 03/14/23, 03/23/23, 03/25/23, 03/26/23, 03/27/23 and 04/01/23 for the insulin administration. Chart coded "9" is the equivalent of "other/see nurses	F 658	4. An audit of all medication records will be completed by DON/Designee to ensure the Provider is aware of refusals/omissions and all resolved wounds weekly x 8 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the QA process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 6/2/23	

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F 658	Continued From page 9 notes." The eMAR was coded "15" on 04/02/23 and 04/05/23 for the insulin administration. Chart code "15" is the equivalent of "No insulin required." Resident #99's clinical record contained nurse's progress notes, which read in part, "03/14/2023 14:08 Semglee solution 100 unit/ml. Inject 18 units subcutaneously at bedtime for DM. Refused.", "03/23/2023 19:49:04 Semglee solution 100 unit/ml. Inject 18 units subcutaneously at for DM. resident refused. BS (blood sugar) 98.", "03/25/2023 20:47 Semglee solution 100 unit/ml. Inject 18 units subcutaneously at for DM. refused.", "03/26/2023 20:08 Semglee solution 100 unit/ml. Inject 18 units subcutaneously at for DM. Drug refused. Resident states he/she does not need it with bloodsugar 148.", "04/01/2023 21:43 Semglee solution 100 unit/ml. Inject 18 units subcutaneously at for DM. Resident declined to take lantus r/t (related to) risk of low glucose.", and "04/05/2023 20:03 Semglee solution 100 unit/ml. Inject 18 units subcutaneously at for DM." There were no corresponding notes for 03/02/23, 03/04/23 and 04/02/23. There was no documentation that the physician had been notified of the refusals. Surveyor spoke with the director of nursing (DON) on 04/26/23 at 12:05 pm regarding Resident #99's insulin. Surveyor asked DON if the physician should have been notified of the resident's refusals and DON stated, "Just good nursing practice to, so yeah." DON later stated to surveyor that "15" coded on eMAR were resident refusals, and that they were going to start education on notifying physician and charting refusals.	F 658		

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F 658	Continued From page 10 Surveyor requested and was provided with a facility policy entitled "Requesting, Refusing, and/or Discontinuing Care or Treatment", which read in part "Residents have the right to request, refuse, and/or discontinue treatment prescribed by his or her healthcare practitioner, as well as care routines outline on the resident's assessment and plan of care. 3. The resident is not forced to accept any medical care and may refuse or discontinue care or treatment at any time. This includes treatment prescribed by the physician, care or treatment that has been administered previously, and/or care or treatment that the resident previously agreed to but has not yet been administered. 13. The healthcare practitioner will be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request ..." The concern of not following professional standards of practice was discussed with the administrator, DON, and assistant director of nursing on 04/26/23 at 4:15 pm. No further information was provided prior to exit. 2. For resident #376, the facility staff signed off on wound care to the sacrum that they were not providing. Resident #376 diagnoses included, but were not limited to, congested heart failure, chronic obstructive pulmonary disease, cellulitis of the left lower limb, atrial fibrillation, pneumonia and malnutrition.	F 658		

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F 658	Continued From page 11 The admission Minimum Date Set Assessment (MDS), with an Assessment Reference Date (ARD) of 4/12/23 assigned the resident a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating that resident #376 was cognitively intact. Resident #376 was coded in section G of the MDS as requiring extensive assistance of one or two people with bed mobility, transfers, toileting and personal hygiene. In section H of the MDS, resident #376 was coded as being occasionally incontinent of urine and mostly incontinent of bowel. Under section M of the MDS, the resident was coded as being at risk for developing pressure ulcers and was coded as requiring daily application of non-surgical dressings. There were no pressure ulcers or venous/arterial ulcers coded. A review of resident #376's orders revealed the following entered on 4/7/2023, "Cleanse sacrum with facility approved wound cleanser, cover with hydrofera blue and mepliex every day and PRN" (as needed). The treatment administration record (TAR) was reviewed, and facility staff had been signing off on this order daily from April 8, 2023 to April 25, 2023, indicating that the order was being carried out. There was one blank on the TAR for April 17, 2023 indicating that the treatment had not been done on that date. On 4/26/23 at 9:50 AM, surveyor interviewed resident #376 to inquire about the wound on her sacrum. Resident informed surveyor that there was no wound on her sacrum. Resident denied any wound care being performed on her sacrum. Resident stated that she had a wound on her left leg that the nurses were treating but no others on her body.	F 658		

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F 658	Continued From page 12 Surveyor interviewed LPN #1 on 4/26/23 at 10:00 AM. Surveyor asked why resident #376 had orders for wound care to her sacrum as the resident stated she had no wound, and no wound care was being provided. LPN #1 stated that they had put the order in on admission so the hospital must have sent the order and that they were positive resident #376 had a pressure area in the hospital. Surveyor asked if nurses were signing off on an order that they were not administering, and LPN #1 stated she was not sure and "maybe they were applying just a regular foam dressing because there's an order for a dressing". LPN #1 informed the surveyor that they were discontinuing the order, "right now". LPN #1 was unable to produce any documentation from the hospital giving an order for wound care to the sacrum or documentation to support that resident #376 had a pressure area in the hospital. On 4/26/23 at 12:40 PM, surveyor interviewed the wound nurse LPN # 9. LPN #9 stated that they were not aware of any wound to resident #376 sacrum. On 4/26/23 at 3:50 PM surveyor interviewed LPN # 7. Surveyor asked if they were familiar with resident #376 and they stated, "Yes, I am". Surveyor asked if LPN # 7 had performed wound care to resident #376's sacrum to which they stated, "No, I've never done any wound care to (name omitted) sacrum". LPN # 7 went on to state, "(name omitted) has never had a dressing on her sacrum. I gave her a shower the other day, there was no dressing. I have seen her bottom multiple times, never any dressing there". Surveyor requested and received the policy	F 658		

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F 658	Continued From page 13 entitled, "Charting and Documentation" on 4/26/23 from the Director of Nursing (DON). The policy read in part, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." On 4/26/23 at 4:17 PM the survey team met with the Administrator and Director of Nursing and this concern was reviewed. No further information was provided to the survey team prior to the exit conference.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined	F 660	F-660 1. DON spoke with Representative of #325 regarding the discharge process and spoke with the facility #325 was transferred to assure resident was adjusting well and offered assistance. 2. All discharges were audited for discharge planning and notification of representatives over the last 30 days.	

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F 660	Continued From page 14 by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient	F 660	3. All department heads and licensed nurses were educated that their assigned section of the discharge summary should be completed, reviewed and signed prior to discharge from the facility. Each discipline is responsible for ensuring any necessary education with resident, family members or facility resident is transferring to. All residents and representatives should be made aware of all discharge plans and determine that the plans in place will ensure residents are safe and receive continuity of care. A copy of the discharge summary will be provided to Resident and/or RP. 4. An audit of all discharges will be conducted to ensure discharge planning is reviewed and documented thoroughly. This will be reviewed by the Department Heads in the morning meeting and concerns discussed 5xweek x 8 weeks. These results will be reviewed and discussed by the interdisciplinary Team through the QA process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 6/2/23	

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F 660	Continued From page 15 assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility document review, the facility staff failed to develop and implement an effective discharge planning process for 1 of 4 residents in the closed record sample. The findings include: For resident #325, the facility staff failed to involve the resident representative in the development of the discharge plan and inform the resident representative of the final plan to transfer the resident to another facility. Resident #325's diagnoses included but were not limited to unspecified dementia, insomnia, anxiety disorder, macular degeneration, hypertension and muscle weakness. The most recent Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 1/24/23 assigned resident #325 a Brief Interview for Mental Status (BIMS) score of 3 out	F 660		

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F 660	Continued From page 16 of 15 indicating severe cognitive impairment. The MDS also revealed that resident had no signs or symptoms of delirium and no behavior symptoms during the assessment review period. Resident #325 was documented as requiring supervision to limited assistance with mobility and activities of daily living such as toileting, eating and hygiene. Review of resident 325's clinical record on 4/25/23 revealed that they were discharged to another long-term care facility on 3/30/23. A physician's progress note dated 3/30/23 read in part, "Will d/c (discharge) to inpatient rehab with resolution of rhabdomyolysis. Patient became combative overnight on 12/7/22 and was given Haldol, unable to d/c to facility due to this. Patient is now medically stable and afebrile on room air. Patient is not oriented today and is confused secondary to (omitted) history of dementia". The note went on to say, "The patient is discharging today". The clinical record also included an assessment entitled "Discharge Planning Review v1.1". The assessment was comprised of 5 sections with only Section 1 entitled, "Discharge Goals/General Information" being partially completed. Section 2 entitled, "Self Care Evaluation and Equipment" was blank. Section 3 entitled, "Learning and Care Needs" was blank. Section 4 entitled, "Contacts and Discharge Information" was blank. Section 5 entitled signatures had one staff member signature for the social worker that was dated 3/30/23. The lines in section 5 for resident signature and resident representative signature were blank. Surveyor was unable to locate a note in the clinical record that a resident representative had been notified of resident #325's discharge on or prior to 3/30/23. There is an adult child listed on resident #325's demographic sheet as	F 660		

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F 660	Continued From page 17 "responsible party" and "care conference person". On 4/25/23 at 1:20 PM surveyor interviewed the facility social work assistant. When asked who would have notified resident #325's family of their discharge, they stated, "It would have been myself. I was under the impression that Adult Protective Services (APS) was getting guardianship and I had notified them. I didn't know I still needed to notify (name omitted)". They went on to state that resident #325's responsible party had attended a care plan meeting on 3/3/23 via Zoom call in which the need for a locked unit had been discussed and that the family member had instructed them to begin searching for a facility, so the family was aware that resident #325 was going to be leaving but they were not notified when. Social worker assistant was not able to produce documentation of the care plan meeting or definitive proof that a family member had attended. On 4/25/23 at 2:35 PM surveyor interviewed the Director of Nursing (DON) who stated, "During the last care plan conference we discussed memory care with the family. (omitted) came to us as an open APS case, so (name omitted) notified APS of the discharge and thought that they would notify the family". The DON was unable to produce documentation of the care plan conference. When asked about the Discharge Planning Review in the medical record the DON did state that each section of the form should be completed by the Interdisciplinary Team, each team member and the resident or resident representative should sign and date it and a copy should be sent to the accepting facility. DON acknowledged that this did not happen in the case of resident #325 and stated that the facility	F 660		

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F 660	Continued From page 18 was working on a 4 point plan to correct the issue. Surveyor requested and received a copy of the policy entitled, "Discharge Planning" which read in part, "The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions." Under the section entitled, "Specific Procedures/Guidance", item #3 read in part, "The discharge plan will: a. involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representatives of the final plan; c. Ensure that the discharge needs of each resident are identified. d. Incorporate caregiver/support person availability". Under item #6, the policy read in part, "If a resident is transferred to another skilled nursing facility c. Document timely in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation will be discussed with the resident or resident's representative. All relevant information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer". The policy went on in section #7, "When the facility anticipates discharge, the facility will prepare discharge summary that includes, but is not limited to a recapitulation of the resident's diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results". The survey team met with the Administrator and	F 660		

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F 660	Continued From page 19 DON on 4/26/23 at 4:17 PM and this concern was discussed. No further information was provided to the survey team prior to the exit conference.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review and staff interviews, the facility staff failed	F 661	Past noncompliance: no plan of correction required.	

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F 661	Continued From page 20 to complete a discharge summary for one of 4 residents in the closed record sample. The findings include: For resident #325 the facility staff failed to complete a discharge summary that included a recapitulation of the resident's stay, diagnoses, course of illness/treatment, a summary of the resident's status, reconciliation of all medications, a post-discharge plan of care developed with the participation of the resident and/or resident representative. Resident #325's diagnoses included but were not limited to unspecified dementia, insomnia, anxiety disorder, macular degeneration, hypertension and muscle weakness. The most recent Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 1/24/23 assigned resident #325 a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating severe cognitive impairment. The MDS also revealed that resident had no signs or symptoms of delirium and no behavior symptoms during the assessment review period. Resident #325 was documented as requiring supervision to limited assistance with mobility and activities of daily living such as toileting, eating and hygiene. Review of resident 325's clinical record on 4/25/23 revealed that they were discharged to another long-term care facility on 3/30/23. A physician's progress note dated 3/30/23 read in part, "Will d/c (discharge) to inpatient rehab with resolution of rhabdomyolysis. Patient became combative overnight on 12/7/22 and was given Haldol, unable to d/c to facility due to this. Patient is now medically stable and afebrile on room air.	F 661		

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F 661	Continued From page 21 Patient is not oriented today and is confused secondary to (omitted) history of dementia". The note went on to say, "The patient is discharging today". The clinical record also included an assessment entitled "Discharge Planning Review v1.1". The assessment was comprised of 5 sections with only Section 1 entitled, "Discharge Goals/General Information" being partially completed. Section 2 entitled, "Self Care Evaluation and Equipment" was blank. Section 3 entitled, "Learning and Care Needs" was blank. Section 4 entitled, "Contacts and Discharge Information" was blank. Section 5 entitled signatures had one staff member signature for the social worker that was dated 3/30/23. The lines in section 5 for resident signature and resident representative signature were blank. Surveyor was unable to locate a note in the clinical record that a resident representative had been notified of resident #325's discharge on or prior to 3/30/23. There is an adult child listed on resident #325's demographic sheet as "responsible party" and "care conference person". On 4/25/23 at 1:20 PM surveyor interviewed the facility social work assistant. When asked who would have notified resident #325's family of their discharge, they stated, "It would have been myself. I was under the impression that Adult Protective Services (APS) was getting guardianship and I had notified them. I didn't know I still needed to notify (name omitted)". They went on to state that resident #325's responsible party had attended a care plan meeting on 3/3/23 via Zoom call in which the need for a locked unit had been discussed and that the family member had instructed them to begin searching for a facility, so the family was aware that resident #325 was going to be leaving	F 661		

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F 661	Continued From page 22 but they were not notified when. Social worker assistant was not able to produce documentation of the care plan meeting or definitive proof that a family member had attended. On 4/25/23 at 2:35 PM surveyor interviewed the Director of Nursing (DON) who confirmed that the document in the clinical record entitled "Discharge Planning Review v1.1" is the discharge summary. When asked about the Discharge Planning Review being incomplete the DON did state that each section of the form should be completed by the Interdisciplinary Team, each team member and the resident or resident representative should sign and date it and a copy should be sent to the accepting facility. DON acknowledged that this did not happen in the case of resident #325 and stated that the facility was working on a 4-point plan to correct the issue. Surveyor requested and received a copy of the policy entitled, "Discharge Planning" which read in part, " When the facility anticipates discharge, the facility will prepare discharge summary that includes, but is not limited to a recapitulation of the resident's diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results". The survey team met with the Administrator and DON on 4/26/23 at 4:17 PM and this concern was discussed. No further information was provided to the survey team prior to the exit conference.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

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F 684	Continued From page 23 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 observation, resident interview, staff interviews, clinical record review, and facility document review the facility staff failed to ensure residents received treatment and care in accordance with provider orders and the comprehensive person-centered care plan for 2 of 26 current residents, Resident #88 and #66. The findings were: 1. Facility staff failed to ensure Resident #88 received a medication, Gabapentin, on 3/22/23 and 3/23/23 as scheduled per a provider order. Resident #88's face sheet listed diagnoses included but were not limited to spinal stenosis, chronic pain, scoliosis, low back pain, osteoarthritis, fibromyalgia, and post laminectomy syndrome. The minimum data set with an assessment reference date of 01/19/23 coded the resident's brief interview for mental status a 15 out of 15 In Section C (cognitive patterns). Resident #88's clinical record included a provider's order for Gabapentin Capsule 100 mg by mouth at bedtime for pain. The medication order started on 12/13/22. Upon meeting Resident #88 on 4/24/23, she	F 684	F-684 1. Gabapentin has been filled and made available for resident #88. Grab bars were placed on the bed for resident #66. 2. Medication Cart to order audit to be completed on each unit to ensure each Physician order is followed. An audit has been completed on every resident to ensure grab bar orders are followed. Staff has confirmed that with each order there has been an assessment and consent completed and the bars are located on the bed correctly. 3. All licensed nurses will be educated on the process for reordering medications prior to the last dose being given. This will allow the pharmacy to fill and deliver medications without any delay in treatment. All licensed nurses will be educated that a requer will be completed for maintenance to make any grab bar or bed adjustments. Assessments and consents will be completed and careplans modified before any change is made.	

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F 684	Continued From page 24 reported having missed some doses of pain medication in the recent past. Staff told the resident the medication had run out and the pharmacy would not provide the code needed to obtain the medication. The resident had spoken to the nurse practitioner (NP) about the issue and stated the NP was trying to take care of the problem. The resident's medication administration record (MAR) for March 2023 showed the number nine documented for the 9:00 p.m. dose of Gabapentin on both 3/22/23 and 3/23/23 which meant "Other/See Progress Notes." A licensed practical nurse (LPN) wrote on 3/22/23 at 9:01 p.m. the pharmacy was contacted regarding the Gabapentin and was told the resident needed a signed prescription. The LPN printed the prescription and placed it in the "MD folder" for signature. Resident #88 was made aware. The same LPN wrote the next evening, 3/23/23 at 9:17 p.m., the pharmacy was called numerous times for a code to pull the Gabapentin but the pharmacy did not answer. The LPN was unable to pull the medication without the code from the pharmacy and the resident was notified of the issue. On 4/26/23 at 2:15 p.m., the director of nursing (DON), assistant director of nursing (ADON) and the D wing unit manager (an LPN) were interviewed in person regarding Resident #88's Gabapentin missed doses. The ADON acknowledged the resident did not receive Gabapentin as scheduled on 3/22/23 and 3/23/23. The DON reported when a medication runs out, staff must call the pharmacy to obtain a code in order to retrieve the medication from the Pyxis machine. When the medication was a	F 684	4. An audit will be conducted to ensure medications are ordered timely x 8 weeks. An audit will be completed weekly to ensure grab bar orders have been processed correctly as evidenced by placement on/off the bed correctly, assessments and consents completed and care plans modified accordingly x 8 weeks. These results will be reviewed and discussed by the interdisciplinary team through the QA process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 6/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 25 narcotic (such as Gabapentin), the pharmacy required a signed, paper prescription. The facility's on-call provider service will not sign a prescription for a narcotic. The expectation was the printed prescription would be placed in the "MD folder" for the provider to sign when they return. The DON stated their on-call provider was a corporation who had providers "all over the place" and the staff have a phone number they call but the staff never knows who will call back. The on-call provider service would be called during any hours the facility's NP was not onsite. The DON acknowledged the "ball was dropped by nursing, there should have been a script printed and left for the NP to sign before they ran out of medication." The DON said the ADON was currently educating staff to make checks in the medication cart every Wednesday to see whether there was enough medication to last through the weekend. If not, the staff were to print a prescription and leave it for the NP to sign prior to the weekend. The DON also stated the NP was trying to work with the on-call company to see whether they would agree to sign prescriptions for narcotics the residents were already taking on a scheduled basis. The facility's policy titled, "3.3 ORDERING AND RECEIVING CONTROLLED MEDICATIONS" read in part for refill requests, "...requested from the pharmacy a minimum of 3 days in advance of need to assure an adequate supply is on hand." The administrator, DON and ADON were informed of the above-described concern on 4/26/23 at 4:17 p.m. summary meeting.	F 684		

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F 684	Continued From page 26	F 684		

2. For Resident #66, the side rail assessment, physician's orders, and comprehensive person-centered care plan indicated the need for grab bars/side rails, however, none were present on the resident's bed.

Resident #66's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Major Depressive Disorder, Anxiety Disorder, and Epilepsy.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/02/23 coded the resident as being moderately impaired in cognitive skills for daily decision making with short term and long term memory problems. Resident #66 was coded as requiring extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.

A review of Resident #66's clinical record revealed a current physician's order dated 12/20/22 for grab bars x 2 for bed mobility and safety in transferring. The resident's comprehensive person-centered care plan included an intervention dated 12/21/22 for the use of side rails to maximize independence with turning and repositioning in bed.

Resident #66's clinical record also included a Side Rail and Entrapment Risk Assessment dated 12/20/22 stating in part that the resident would benefit from the use of grab bars by helping with bed mobility and transferring.

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F 684	Continued From page 27 On 4/25/23 at 9:00 am, surveyor observed Resident #66 in bed with the left side of the bed against the wall with no grab bars or side rails attached to the bed. On 4/26/23 at 1:40 pm, surveyor spoke with licensed practical nurse (LPN) #8 and asked what type of rails should be in place on Resident #66's bed. LPN #8 reviewed the resident's orders and stated the resident should have grab bars in place and went on to say that they recently changed the resident's bed by placing it against the wall. Surveyor then asked if Resident #66 needed grab bars and LPN #8 stated "honestly no" and further stated that the resident's dementia has increased and does not think the grab bars would assist them at this point. LPN #8 stated they were going to discontinue the order for the grab bars. On 4/26/23 at 4:17 pm, the survey team met with the administrator, director of nursing, and the assistant director of nursing and discussed the concern of Resident #66 not having grab bars in place. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/26/23.	F 684		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727	F-727 1. The facility cannot correct this deficient practice. 2. All residents of the facility have the potential to be affected by this deficient practice.	

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F 727	Continued From page 28 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews and facility document review, the facility staff failed to ensure a registered nurse was working at the facility for two (2) of 30 days reviewed for nursing staffing. The findings include: The facility staff failed to have a registered nurse (RN) working at the facility for the following two days: 4/8/23 and 4/22/23. Review of the facility's posted staffing information forms failed to show a RN working at the facility on the following four (4) days: 4/4/23, 4/8/23, 4/14/23, and 4/22/23. The administrator was able to provide evidence of a RN working on 4/4/23 and 4/14/23. On 4/25/23 at 3:37 p.m., the Administrator reported no RN was working at the facility on 4/8/23 and 4/22/23; the Administrator reported an RN should have been working at the facility on those days. On 4/25/23 at 3:50 p.m., the Director of Nursing (DON) confirmed the aforementioned dates did not have a RN coverage; the DON stated it could have been due to a call out.	F 727	3. The facility has partnered with Terradin, Medical Staffing Solutions, and Gale (staffing agency) to secure an Administrative Registered Nurse to ensure the needs of the residents are met per regulation for 8 weeks while the facility recruits additional Registered Nurses. 4. The facility has a staffing meeting Monday through Friday to ensure Registered Nurse coverage for a minimum of 8 consecutive hours 7 days a week. The facility has contracted with several local staffing agencies as a contingency plan in the event the facility employed Registered nurses have called off. The monthly staffing schedule will be reviewed by the facility QAPI Committee x 8 weeks. The QAPI Committee is responsible for the ongoing monitoring of compliance. 5. Date of Compliance: 6/2/23	

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F 727	Continued From page 29 On 4/26/23 at 4:17 p.m., the survey team met with the Administrator, Director of Nursing, and Assistant Director Nursing. The failure of the facility staff to ensure a RN was working on 4/8/23 and 4/22/23 was discussed.	F 727		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756	F-756 1. AIMS reviewed and updated as needed for resident #108. 2. An audit of all residents with antipsychotic medications has been completed to ensure that each resident is monitored quarterly. 3. All licensed nurses have been educated that an AIMS form is to be completed quarterly for each resident receiving antipsychotic medications. 4. An audit of all residents requiring an AIMS form will be done weekly x 8 weeks. These results will be reviewed and discussed by the interdisciplinary team through the QA process and corrective action plans put into place as indicated on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 6/2/23	

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F 756	Continued From page 30 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure a medical provider approved medication regimen review (MRR) recommendation was implemented for one (1) of five (5) residents sampled for MRRs. The MRR recommendation had to be requested by the pharmacist a second time prior to it being implemented. The findings include: The facility staff failed to perform and/or implement monitoring for abnormal movements as recommended by a pharmacist, as part of Resident #108's MRR dated 12/10/23. This MRR was signed by a medical provider with the request to add AIMS to nursing tasks. (The Abnormal Involuntary Movement Scale (AIMS) is used to evaluate/monitor individuals who are receiving medications whose side effect include abnormal body movements.) Resident #108's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/9/23, was signed as completed on 4/17/23. Resident #108 was assessed as sometimes being able to make self understood and as sometimes being able to understand	F 756		

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F 756	Continued From page 31 others. Resident #108's Brief Interview for Mental Status (BIMS) summary score was documented as a seven (7) out of 15; this indicated severe cognitive impairment. Resident #108 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #108's MRR dated 1/8/23 indicated the AIMS assessment was not found in the resident's chart; the pharmacist who completed this MRR included a "2nd Request" for the abnormal movement test/monitoring. The AIMS was documented as completed on 2/21/23. On 4/26/23 at 4:17 p.m., the survey team met with the Administrator, Director of Nursing, and Assistant Director Nursing. The failure of facility staff to timely implement a medical provider approved MRR pharmacist recommendation was discussed.	F 756		
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	F 770	F-770 1. Provider was made aware that the flu test was not collected for resident #78. 2. A lab audit for the last 30 days was completed to ensure that all specimens were collected, and results recorded. 3. All licensed nurses have been educated to record all lab orders in the lab log so staff are aware of who has specimens ordered and what results may be pending.	

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F 770	Continued From page 32 needs of the resident for 1 of 26 residents in the survey sample, Resident #78. The findings included: For Resident #78, the facility staff failed to perform a flu test as ordered by the medical provider. Resident #78's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Chronic Kidney Disease Stage 5, Essential Hypertension, and Type 2 Diabetes Mellitus. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 2/09/23 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 indicating the resident was severely cognitively impaired. A review of Resident #78's clinical record revealed a nursing progress note dated 4/10/23 at 5:56 pm which read in part "This nurse was called to the dining room by CNA [certified nursing assistant] staff while attempting to assist resident in eating [their] dinner. Staff report increased lethargy. VS [vital signs] obtained at this time ...axillary temp found to be 102.8. Resident also noted to have a course cough ...Call placed to [name omitted], NP [nurse practitioner], with new orders given for rapid COVID and Flu swab and STAT CBC [complete blood count] and CMP [complete metabolic panel] ...Will notify [name omitted] once labs and swabs are completed." Surveyor reviewed Resident #78's clinical record and was unable to locate results for the flu swab	F 770	4. A lab audit will be conducted in the Clinical Meeting daily x 5 days a week to ensure specimens are collected and results are noted x 8 weeks. These results will be reviewed and discussed by the interdisciplinary team through the QA process and corrective action plans put into place as indicated on review, along with determinations related to ongoing monitoring. 5. Date of compliance: 6/2/23	

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F 770	Continued From page 33 test. On 4/25/23 at approximately 10:15 am, surveyor spoke with the assistant director of nursing (ADON) who stated they did not have Resident #78's flu swab results because it was not collected. On 4/25/23 at 11:22 am, surveyor spoke with the NP who stated they also could not locate the flu swab results and they only ordered it to cover all bases but Resident #78 was symptomatic for a urinary tract infection. Surveyor attempted to interview the nurse who received the order for the flu swab test, however, they were no longer employed by the facility. Surveyor requested and received the facility policy entitled "Lab and Diagnostic Test Results" which read in part " ... The staff will process test requisitions and arrange for tests as ordered ..." On 4/25/23 at 4:47 pm, the survey team met with the administrator and director of nursing and discussed the concern of staff failing to complete a flu swab test on Resident #78 as ordered by the provider. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/26/23.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		

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F 842	Continued From page 34 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or	F 842	F-842 1. Facility corrected record to indicate the correct date (4/13/23) was documented for resident #105 and that resident #105 slapped another resident's hand and not the face. The facility cannot correct this deficient practice. 2. An audit of all FRIs for the last 30 days was conducted to ensure that each event was documented promptly and completely. DON met with the consulting Pharmacist and the Director of Pharmerica to determine how to document their services more effectively for each unit. The consulting Pharmacist will print each note with one resident listed per page so that it may be uploaded into the resident record. 3. All Clinical Staff will be educated in the importance of recording information promptly and correctly. The Consulting Pharmacist has been educated that each resident must be documented separately so that it may be uploaded into their record without violating their privacy.	

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F 842	Continued From page 35 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record review, and facility document review, the facility staff failed to maintain complete and/or accurate clinical record/documentation for three (3) of 26 sampled current residents (Resident #25, Resident #105, and Resident #108). The findings include: 1. Documentation of a resident-to-resident altercation involving Resident #105 was noted to be incomplete and/or accurate. Resident #105's minimum data set (MDS) assessment, with an assessment reference date	F 842	4. An audit of all events will be conducted to ensure documentation is recorded promptly and accurately every week x 8 weeks. The Pharmacy recommendations will be audited each month x 2 to ensure that each resident is listed separately and can be uploaded in their record without violating their privacy. These results will be reviewed and discussed by the interdisciplinary team through the QA process and corrective action plans put into place as indicated on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 6/2/23	

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F 842	Continued From page 36 (ARD) of 1/16/23, was signed as completed on 1/23/23. Resident #105 was documented as able to make self understood and as able to understand others. Resident #8's Brief Interview for Mental Status (BIMS) summary score was documented as an eight (8) out of 15; this indicated moderate cognitive impairment. Resident #105 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #105's clinical documentation included a progress note with an effective date and time of 4/14/23 at 9:49 a.m. This note indicated Resident #105 had allegedly "slapped" another resident in the face. The facility's administrative team provided the surveyor with a Facility Reported Incident (FRI) and investigation for an event dated 4/13/23 in which Resident #105 was alleged to have "slapped" a resident's hand. On 4/25/23 at 4:45 p.m., the survey team met with the Administrator and Director of Nursing (DON). The surveyor requested any additional information related the aforementioned alleged event or events involving Resident #105 which either occurred on 4/13/23 and/or 4/14/23. On 4/26/23 at 11:17 a.m., Licensed Practical Nurse (LPN) #8 reported they did not recall an alleged facial slap; LPN #8 stated they did recall an alleged slap to a hand. After reviewing the aforementioned progress note (4/14/23 at 9:49 a.m.) LPN #8 confirmed the electronic/computerized note appeared to be their documentation. LPN #8 reported they did not recall documenting about a facial slap. On 4/26/23 at 11:20, the Director of Nursing	F 842		

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F 842	Continued From page 37 (DON) reported there was only one event which occurred on 4/13/23. The DON stated the resident, that was allegedly slapped, was interviewed and denied being slapped in the face. The DON reported they believe the event was documented as a late entry on 4/14/23 and that the facility staff member failed to change the effective date to the correct date. The following information was found in a facility document titled "Charting and Documentation" (this document was not dated): - "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. - "The following information is to be documented in the resident medical record: ... Objective observations ... Treatments or services performed ... Events, incidents, or accidents involving the resident ..." - "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." On 4/26/23 at 4:17 p.m., the survey team met with the Administrator, Director of Nursing, and Assistant Director Nursing. The failure of Resident #105's clinical documentation being complete and/or accurate was discussed. 2. Resident #25's clinical documentation failed to consistently include documentation of monthly medication regimen reviews (MRRs).	F 842		

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F 842	Continued From page 38 Resident #25's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 3/19/23, was signed as completed on 3/23/23. Resident #25 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #25's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact and/or borderline cognition. Resident #25 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #25's clinical documentation failed to include evidence of a MRR being completed by a pharmacist for the months of January 2023 and April 2023. The surveyor was provided copies of forms titled "Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations" for January of 2023 and April of 2023. Resident #25's name appeared on the forms for both months. This information was not part of Resident #25's clinical record. 3. Resident #108's clinical documentation failed to consistently include documentation of monthly medication regimen reviews (MRRs). Resident #108's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/9/23, was signed as completed on 4/17/23. Resident #108 was assessed as sometimes being able to make self understood and as sometimes being able to understand others. Resident #108's Brief Interview for Mental Status (BIMS) summary score was documented as a seven (7) out of 15; this indicated severe	F 842		

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F 842	Continued From page 39 cognitive impairment. Resident #108 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #108's MRR dated 3/8/23 included a request for an evaluation of psychotropic medications for a potential gradual dose reduction. This was declined by a medical provider based on the resident's response to the medication. This MRR and the medical provider rational for declining the pharmacist's recommendations were not part of Resident #108's clinical record. The MRR and the provider's documentation were part of a document which contained information about another resident, in addition to the information about Resident #108. On 4/26/23 at 10:10 a.m., the Director of Nursing (DON) and a Regional Nurse Consultant (RNC), confirmed that MRR information, completed by the revlewing pharmacist, was not entered into specific resident clinical records/charts when the MRR information of more than one (1) resident was included on the same page. On 4/26/23 at 4:17 p.m., the survey team met with the Administrator, Director of Nursing, and Assistant Director Nursing. The failure of facility staff to ensure pharmacist MRRs and/or provider responses to the MRR recommendations were documented as part of residents' clinical documentation was discussed.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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F 880	Continued From page 40 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: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	1. The facility has written evidence of current blood glucose policy and procedures. 2. Training: Highland Ridge Rehab Center has a blood glucose policy and procedure. Licensed nursing staff will be educated on the blood glucose policy and procedure. a. Highland Ridge Rehab Center will conduct annual competencies for all licensed nursing staff to include blood glucose testing. 3. Implementation: The facility will conduct annual competencies for all licensed nursing staff with the help of SDC, DON and nursing management staff 4. Systemic changes: the facility will conduct annual competencies for all licensed nursing staff and will observe licensed nursing staff obtain blood glucose using proper procedures. 5. Monitoring: The DON or designee will observe licensed nursing staff obtaining blood glucose 3x/week x 8 weeks. The DON or Designee will provide individual education when necessary. Date of compliance: 5/24/23	

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F 880	Continued From page 41 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 document review, the facility staff failed to ensure gloves were worn by a staff member when completing a finger stick blood sugar (FSBS) test for one (1) of 26 sampled current residents (Resident #58). The findings include: On 4/25/23 at 9:05 a.m., Licensed Practical Nurse (LPN) #2 was observed to perform a FSBS test for Resident #58 without wearing gloves. LPN #2 confirmed they should have been wearing	F 880		

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F 880	Continued From page 42 gloves. Resident #58's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/5/23, was dated as completed on 4/7/23. Resident #58 was assessed as able to make self understood and as able to understand others. Resident #58's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition. Resident #58 was assessed as requiring assistance with bed mobility, transfers, dressing, eating, and personal hygiene. Resident #58's diagnoses included diabetes. The following information was found in a facility document titled "Point Of Care Devices (Blood Glucose Meters/PT/INR Meters) Use and Cleaning" (this document was dated 3/11/19): - "The facility will maintain processes to prevent the spread of infection and disease and to ensure that Point of Care Devices are utilized safely when used on multiple residents by properly cleaning the devices between each resident." - "Standard precautions will be used when handling the device and performing tests." The following information was found in a document titled "Isolation Precautions" under the heading of "Standard Precautions" on the Centers for Disease Control and Prevention (CDC) website (downloaded on 4/28/23): - "Wear PPE ... when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur." (PPE is personal protective equipment which includes gloves.) - "Wear gloves when it can be reasonably anticipated that contact with blood or other	F 880		

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F 880	Continued From page 43 potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur." On 4/26/23 at 4:17 p.m., the survey team met with the Administrator, Director of Nursing (DON), and Assistant Director Nursing. The failure of LPN #2 to wear gloves when performing a FSBS sample collection and test was discussed. The DON confirmed LPN #2 should have worn gloves when performing the FSBS test.	F 880		