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	495344	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(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 01/31/2023 through 02/2/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/31/2023 through 2/2/2023. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 95 at the time of the survey. The survey sample consisted of 19 current Resident reviews and three closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and staff interview, the facility staff failed for one of 22 residents in the survey sample (Resident # 10) to ensure an accurate Minimum Data Set. Resident #10 was inaccurately identified on a Significant Change Minimum Data Set (MDS) as not receiving hospice services. The findings were: Resident # 10 was admitted with diagnoses that	F 641	1. On **2-01-23** Resident #10's MDS (Minimum Data Set) was modified by the nurse to include hospice 2. Residents receiving Hospice services were reviewed by the MDS nurse/designee to ensure an accurate MDS assessment. 3. The Regional MDS nurse re-educated the MDS nurses related to MDS accuracy. 4. 4. MDS nurse or designee to conduct random weekly QI monitoring for 4 weeks then monthly for 2 months of the residents' MDS section O0100.K to ensure an accurate MDS. Findings to be reviewed during Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings.	3-08-23

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

Jeffrey Shrewsbury | Executive Director | 3-01-23

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 641	Continued From page 1 included chronic systolic and diastolic heart failure, anemia, atrial fibrillation, coronary artery disease, hypertension, gastroesophageal reflux disease, renal insufficiency, neurogenic bladder, diabetes mellitus, hyperlipidemia, thyroid disorder, arthritis, osteoporosis, anxiety disorder, and respiratory failure. According to the most recent MDS, a Significant Change with an Assessment Reference Date of 1/15/2023, Resident #10 was assessed under Section C (Cognitive Patterns) as moderately cognitively impaired for daily decision making, with a Summary Score of 10 out of 15. Under Section O (Special Treatments, Procedures, and Programs), the question at Item O0100.K, Hospice care, was answered "No". The current Physician's Order sheet in Resident # 10's Electronic Health Record (EHR) included the following order dated 1/2/2023, "Hospice Augusta Health." Review of the Progress Notes, also in the resident's EHR, revealed the following entry: 1/3/2023 - Nursing Progress Notes - "Hospice care started 1/2/23...." At 3:15 p.m. on 2/1/2023, LPN # 2 (Licensed Practical Nurse), the MDS Coordinator, was interviewed regarding the entry under Section O concerning hospice care for Resident #10. LPN # 2 reviewed her notes and then said that the entry at Item O0100.K was incorrect, that the correct response should have been :Yes". The findings were discussed during a meeting at 4:00 p.m. on 2/1/2023 that included the Administrator, the Director of Nursing, and the survey team.	F 641		

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F 655 F 655 SS=D	Continued From page 2 Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F 655 F 655	1. The baseline care plan for resident #293 was revised by a licensed nurse to include interventions for the treatment and care of a PICC line, administration of IV antibiotics, ileostomy care, and treatment to a sacral pressure ulcer on **{2-01-23}**. 2. Residents admitted to the facility in the last 21 days were reviewed by the MDS (Minimum Data Set)/designee to ensure the development of baseline care plans for immediate care upon admission. 3. The DON (Director of Nursing) or designee re-educated the licensed nursing staff on the facility's baseline care plan policy emphasis was placed on developing to ensure immediate care upon admission. 4. The MDS nurse/designee to complete QI (Quality Improvement) monitoring of new admissions via records review to ensure baseline care plans for immediate care. QI monitoring weekly for 4 weeks. Findings to be reviewed during Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings.	3-08-23

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F 655	Continued From page 3 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to develop a baseline care plan for immediate care upon admission for one of 22 residents, Resident # 293. Findings were: Resident #292 was admitted to the facility with the following diagnoses including but not limited to Osteomyelitis, urinary tract infection, Alzheimer disease, diabetes mellitus, and congestive heart failure. Due to her recent admission, no MDS (minimum data set) information was available. Review of Resident #292's clinical record on 02/01/2023, at approximately 10:00 a.m, included orders for the treatment and care of a PICC line, administration of IV antibiotics, ileosotomy care, and treatment to a sacral pressure ulcer. No interventions for these areas was observed on the baseline care plan. The MDS nurse, LPN (licensed practical nurse) #5 was interviewed on 02/01/2023 at approximately 2:00 p.m. regarding baseline care plans. LPN #5 stated, "The admission nurse does the baseline care plan on paper...we use that for 14 days, while comprehensive is completed." She was asked if the above areas should have been	F 655		

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F 655	Continued From page 4 included on the base line care plan. LPN #5 stated, "Yes." The above information was discussed during an end of the day meeting with the DON (director of nursing) and the administrator on 02/01/2022. No further information was obtained prior to the exit conference on 02/02/2023.	F 655		
F 756 SS=E	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	F 756	1. The consultant pharmacist completed a medication regimen review including the medical record for Residents #7, #13, #64, and #75 on **{1/25/23 and 2/23/23}** 2. Those who reside in the facility have the potential to be affected by this alleged deficient practice. The DON/designee reviewed the medication regimen review for the last 30 days to ensure the medical record was reviewed. Follow up based on findings. 3. The ED (Executive Director) re-educated the Consultant Pharmacist on the facility's Monthly Drug Regimen Review policy.	3-08-23

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F 756	Continued From page 5 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §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 interview, facility document review and clinical record review, the facility staff failed to include the medical record as part of a monthly medication regimen review for four of twenty-two residents in the survey sample (Residents #7, #13, #64 and #75). The findings include: Medication regimen reviews for Residents #7, #13, #64 and #75 in December 2022 did not include review of the residents' medical records. 1. Resident #7 was admitted to the facility with diagnoses that included bipolar disorder, insomnia, hemiplegia, diabetes, congestive heart failure, and osteoporosis. The minimum data set (MDS) dated 1/4/23 assessed Resident #7 with moderately impaired cognitive skills for daily decision making. Resident #7's clinical record documented a medication regimen review by the consultant pharmacist dated 12/25/22. The consultation report documented the clinical record was not included as part of the review. Documented in	F 756	4. The DON/designee to complete monthly QI (Quality Improvement) monitoring of the drug regimen reviews to ensure the medical record was included via records review. Findings to be reviewed during Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings.	

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F 756	Continued From page 6 the comment section of this report was, "In lieu of the resident record, [Resident #7's] pharmacy record was reviewed." **2.** Resident #13 was admitted to the facility with diagnoses that included bipolar disorder, depression, COPD (chronic obstructive pulmonary disease), congestive heart failure and arthritis. The MDS dated 12/28/22 assessed Resident #13 as cognitively intact for daily decision making. Resident #13's clinical record documented a medication regimen review by the consultant pharmacist dated 12/26/22. The consultation report documented the clinical record was not included as part of the review. Documented in the comment section of this report was, "In lieu of the resident record, [Resident #13's] pharmacy record was reviewed." **3.** Resident #64 was admitted to the facility with diagnoses that included affective mood disorder, chronic kidney disease, asthma, cognitive communication deficit, vascular dementia with behavioral disturbance, and cerebrovascular disease. The MDS dated 1/3/23 assessed Resident #64 with moderately impaired cognitive skills for daily decision making. Resident #64's clinical record documented a medication regimen review by the consultant pharmacist dated 12/26/22. The consultation report documented the clinical record was not included as part of the review. The comment section of this report documented, "In lieu of the resident record, [Resident #64's] pharmacy record was reviewed."	F 756		

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F 756		F 756		

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4. Resident #75 was admitted to the facility with diagnoses that included dementia, congestive heart failure, and chronic kidney disease. The MDS dated 12/7/22 assessed Resident #75 with moderately impaired cognitive skills for daily decision making.

Resident #75's clinical record documented a medication regimen review by the consultant pharmacist dated 12/25/22. The consultation report documented the clinical record was not included as part of the review. The comment section of this report documented, "In lieu of the resident record, [Resident #75's] pharmacy record was reviewed."

On 2/1/23 at 3:03 p.m., the survey team interviewed the consultant pharmacist (other staff #1) and the director of nursing (DON) about December 2022 medication reviews for Residents #7, #13, #64 and #75. The pharmacist stated he did not have access to the clinical records during most of December 2022 because the computer system for the electronic health records was down. The pharmacist stated only pharmacy records were reviewed in December 2022 due to his lack of access to the clinical records. The DON stated the electronic health record system was down from 12/2/22 until approximately 12/25/22 due to a ransomware issue. The DON stated medication administration records and treatment administration records were printed from backup, so nurses were able to implement physician orders. The DON stated nurses and providers documented notes manually on paper during this time. The pharmacist stated he usually reviewed lab results, provider notes, nursing notes and any documentation related to gradual dose reductions

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F 756	Continued From page 8 during the medication regimen review but was unable to review those items due to the system outage. The pharmacist stated he talked with nursing staff about these residents during the December 2022 medication review but was not able to review the entire clinical record. The pharmacist stated the December 2022 reviews were "not ideal" due to the lack of record access and he anticipated this to be an issue with compliance. The pharmacist stated he had completed reviews for these residents in January 2023 and had "cleaned up" any needed gradual dose reductions and/or recommendations. The facility's policy titled Monthly Drug Regimen Review (revised 10/10/2018) documented, "...During the drug regimen review the consultant pharmacist to identify drug regimen irregularities...Drug regimen irregularities to be communicated to the attending physician, the Medical Director and the DON/designee..." These findings were reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/1/23 at 4:15 p.m.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		

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F 761	Continued From page 9 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h) (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure drugs and biological's were labeled appropriately on one of two nursing units medication room. Findings include: The facility failed to appropriately label a multi-dose vial of Tuberculin on the East unit. On 2/01/23 9:39 AM the East unit medication storage refrigerator was observed with license practical nurse (LPN #3). The refrigerator had one multi-dose vial of tuberculin medication in it's original box. The vial of Tuberculin had been opened and accessed with approximately 1 to 2 doses of the medication remaining in the vial. Neither the vial of Tuberculin nor the original box had an open date, indicating when the medication had been opened/accessed. LPN #3 said, "The vial of Tuberculin should have an open date on it	F 761	1. No residents were identified with this alleged deficient practice. The multi-dose vial of Tuberculin on the East unit was removed once it was brought to the nurses' attention. 2. The DON/designee inspected medication rooms to ensure drugs and biologicals are labeled appropriately. Follow up completed based on findings. 3. The DON/designee re-educated the licensed nurses on the facility's Storage and Expiration Dating of Medications, Biologicals policy. 4. The DON/designee to complete QI monitoring via med room observation to ensure drugs and biologicals are labeled appropriately. QI monitoring to be completed weekly for 4 weeks. Findings to be reviewed during the QAPI Committee Meeting and updated as indicated. QI schedule modified based on findings.	3-08-23

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F 761	Continued From page 10 and should be discarded after 28 days of being opened...since there is no open date it would be discarded." A policy titled, "Administering Medications" documented, "When opening a multi-dose container, the date opened is recorded on the container." On 2/1/23 at 4:15 PM the administrator and DON (director of nursing) were made aware of the above finding. No other information was presented prior to exit conference on 2/2/23.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide a therapeutic diet for one of twenty-two residents in the survey sample (Resident #193). The findings include: Resident #193 was not provided dysphagia mechanical soft food items as ordered by the physician. Resident #193 was admitted to the facility with	F 805	1. Hospice was notified on 2-01-23 a speech therapy was ordered through hospice services. 2. The ED/designee completed a quality review of mechanically altered diets to ensure accuracy. 3. The Dietary Manager/designee re-educated the dietary staff on the Therapeutic diet policy. 4. The ED/designee to complete QI monitoring via observations to ensure therapeutic diets. QI monitoring to be completed 3 days a week times 6 weeks, sample size of 10 random trays. Findings to be reviewed during the QAPI Committee Meeting and updated as indicated. QI schedule modified based on findings.	3-08-23

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F 805		F 805		

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diagnoses that included respiratory failure with hypoxia, COPD (chronic obstructive pulmonary disease), gastroesophageal reflux disease (GERD), chronic kidney disease, hypertension, and arthritis. The admission assessment dated 1/18/23 assessed Resident #193 as cognitively intact.

On 1/31/23 at 11:46 a.m., Resident #193 was interviewed about the quality of care in the facility. Regarding food/meals, Resident #193 stated the she was supposed to get a "modified" diet, but she was receiving regular textured food items. Resident #193 stated that she experienced esophageal burning due to GERD and the softer textured food items were easier for her to swallow.

Resident #193's clinical record documented a physician's order dated 1/25/23 for a regular dysphagia mechanical soft textured diet with regular/thin liquids due to resident's difficulty with swallowing.

On 1/31/23 at 12:47 p.m., Resident #193's lunch was observed. Resident #193 was served shredded chicken with a slice of cheese on a regular bun, mashed potatoes, regular textured Cole slaw and regular fruit cocktail. The meal ticket on this lunch tray did not match the food items served. The meal ticket documented food items as ground cheeseburger, pureed hamburger bun, mashed potatoes, marinated mixed vegetables and pureed fruit cocktail.

On 2/1/23 at 9:48 a.m., the dietary manager (other staff #3) was interviewed about Resident #193's lunch not matching the ordered therapeutic diet or the meal ticket. The dietary

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 12 manager stated the dysphagia mechanical soft diet included pureed food items for breads, fruits, and meats. The dietary manager stated she did not know why the resident was served shredded chicken on a regular bun, the regular fruit cocktail, Cole slaw or why the food items did not match the ticket. On 2/1/23 at 1:08 p.m., the speech therapist (other staff #4) was interviewed about Resident #193's diet. The speech therapist stated that Resident #193 was on hospice and had not been evaluated by speech therapy. The speech therapist stated a dysphagia mechanical soft diet should not include regular textured bread but a bread "slurry," fork tender vegetables and pureed fruits. On 2/1/23 at 1:22 p.m., the dietary manager (other staff #3) was interviewed again about Resident #193. The dietary manager stated she reviewed Resident #193's ordered diet and meal tickets. Other staff #3 stated that the resident #193's prescribed diet was not entered correctly in the "meal tracker" system. The dietary manager stated shredded chicken was not a menu item on 1/31/23 and she did not know how or why that was served. The dietary manager stated that the resident should not have been served regular textured bread, meat, fruit cocktail or Cole slaw. Resident #193's plan of care (initiated 1/24/23) documented the resident was at nutritional risk due to nausea/vomiting, advance age and hospice care. Interventions to provide adequate nutrition and meet resident food preferences included, "...Provide, serve diet as ordered..."	F 805		

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F 805	Continued From page 13 The facility's dietary reference titled "Diet Manual" (2019) documented a dysphagia mechanical soft diet included very tender chopped and/or ground meats, soft fruits without skins, well-cooked chopped vegetables, and well-moistened breads. This manual documented foods to avoid with a dysphagia mechanical soft diet included whole meats, cheese slices, large chunks of fruit, fresh fruits, raw vegetables except shredded lettuce and any dry/crusted breads, biscuits, or toast. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/1/23 at 4:15 p.m.	F 805		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. **(i)** This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. **(ii)** This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. **(iii)** This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812	1. No residents were identified with this alleged deficient practice. 2. Residents being served from the kitchen have the potential of being affected by this alleged deficient practice. The ED/designee conducted a quality review to ensure food is prepared in a sanitary manner. 3. The Dietary Manager/designee re-educated the kitchen staff on how to appropriately thaw food using the facility's Preparation policy. 4. The ED/Designee to conduct QI monitoring to ensure food is prepared in a sanitary manner via observations weekly times eight weeks. Findings to be reviewed during the QAPI Committee Meeting and updated as indicated. QI schedule modified based on findings.	3-08-23

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F 812	Continued From page 14 Based on observation, staff interview and facility document review, the facility staff failed to prepare food in a sanitary manner in the main kitchen. The Findings Include: The kitchen staff were thawing 5 bags of chicken pieces using improper technique. On 1/31/23 at 11:15 AM, during an initial tour of the kitchen, 5 bags containing approximately 20 pieces of chicken per bag was submerged in water without water running over the chicken. At this time, the dietary manager (other staff, OS #2), who also observed the chicken in the sink, was interviewed. OS #2 verbalized that the sink had gotten clogged up so the water was cut off. OS #2 was asked how is the chicken supposed to be thawed. OS #2 verbalized that chicken and frozen meat can be thawed in submerged water with water running over the meat. On 1/31/23 at 11:40 AM, the kitchen was again observed and the chicken had been removed from the sink. On 1/31/23 at 2:00 PM, the director of nursing (DON) was made aware of the above findings and agreed that water should being continuously running over frozen meat. On 2/1/23 at 9:10 AM, the dietary manager trainer (OS #3) was interviewed. When asked what did the staff do with the chicken that was submerged in water, OS #3 verbalized that the chicken temperature was at 30 degrees, so the chicken was removed and placed in the refrigerator on the	F 812		

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F 812	Continued From page 15 bottom rack. The facilities policy titled "Food Preparation" read in part " 5. The cook(s) thaws frozen items that requires defrosting prior to preparation using one of the following methods: [...] Completely submerging the item under cold water (at a temperature of 70 degrees or below) that is running fast enough to agitate and float off loose ice particles." On 2/1/23 at 4:15 PM the administrator and DON was made aware of the above findings. No other information was presented prior to exit conference on 2/1/23.	F 812		
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. **(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	F 842	1. On January 23, 2023 Resident #38 and Resident's son was notified of room change. On 2-01-23 Res #38's medical record was updated by Social Services to include the reason for the room change. 2. Residents with a room change in the last 60 days were reviewed by Social Services/designee to ensure the reason for the room change was documented for a complete and accurate medical record. Follow up completed based on findings. 3. The ED/designee re-educated the Social Services staff on the facility's room change policy.	3-08-23

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F 842	Continued From page 16 §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 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	F 842	4. The ED/SS/Designee to conduct QI monitoring via medical record review to ensure the reason for the room change was documented for a complete and accurate medical records weekly times eight weeks. Findings to be reviewed during the QAPI Committee Meeting and updated as indicated. QI schedule modified based on findings.	

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F 842		F 842		

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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 clinical record review, and staff interview, the facility staff failed for one of 22 residents in the survey sample (Resident # 38) to ensure a complete and accurate clinical record. The reason for a room change was not included in Resident # 38's clinical record.

The findings were:

Resident # 38 was admitted with diagnoses that included congestive heart failure, hypertension, Non-Alzheimer's dementia, depression, psychotic disorder, rheumatoid arthritis, polyneuropathy, immunodeficiency, altered mental status, and osteoporosis. According to the most recent Minimum Data Set (MDS), a Quarterly review with an Assessment Reference Date (ARD) of 12/14/2022, Resident #38 was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired in daily decision making, with a Summary Score of 12 out of 15.

Review of the Progress Notes in Resident # 38's Electronic Health Record (EHR) revealed the following entry:

1/23/2023 - 10:49 a.m. - Nursing Progress Note - "Resident agreeable to room change to 413A. Courtesy call to son as well."

There was no explanation in the resident's EHR

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F 842	Continued From page 18 as to the reason for the room change. At 1:15 p.m. on 2/1/2023, the facility Social Worker was interviewed regarding the room change. According to the Social Worker, Resident #38's roommate was yelling and swearing. "They were not getting along," the Social Worker said. Asked if the reason for Resident # 38's room change should have been documented in the clinical record, the Social Worker replied, "Yes." Resident # 83, the former roommate of Resident # 38, was admitted to the facility with diagnoses that included diabetes mellitus, quadriplegia, acute respiratory failure, history of COVID-19, generalized muscle weakness, dysphagia, abnormal posture, lack of coordination, chronic pain syndrome, and drug induced constipation. According to the most recent MDS, an Admission assessment with an ARD of 1/16/2023, Resident #83 was assessed under Section C (Cognitive Patterns) as being cognitively intact for daily decision making, with a Summary Score of 13 out of 15. Review of the Progress Notes in Resident # 83's EHR revealed the following entry: 1/23/2023 - 4:19 a.m. - Nursing Progress Note - "Resident has yelled out throughout night as soon as his call bell is turned on for help needed. He yells as loud as possible, "I'm calling 911 damnit (sic), you assholes help me, F***!" Staff are answering his call bell as soon as possible to assist with what is needed, and resident is apologetic upon entry about his behavior and yelling; however within 10-15 minutes after staff has walked out of resident's room, he again turns	F 842		

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F 842	Continued From page 19 call bell on and immediately begins yelling aloud. "Somebody come help me damn it (sic) F*** somebody, why don't anyone help me." Staff respond as soon as possible...When asked if he wished to go to the hospital via 911 he refuses, yet continues to yell "SIRI CALL 911" or "F*** you people for not helping me" when staff respond ASAP (As Soon As Possible), nurse has asked would you like to go to the hospital, do you feel your pain is not controlled? Resident responds with his apologetic behavior and states "No I don't want to go to the hospital, why didn't you come to help me." Staff have explained to resident, when assisting another resident we are unable to drop what we are doing and respond as soon as possible. Resident verbalized full understanding, yet approximately 5-10 minutes later he turns on his bell and starts yelling out." The findings were discussed during a meeting at 4:00 p.m. on 2/1/2023 that included the Administrator, the Director of Nursing, and the survey team. No additional informations was presented.	F 842		
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	F 880		

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F 880	Continued From page 20 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 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	F 880	1. Resident #47 & #50 suffered no apparent harm related to this alleged deficient practice. On (2-01-23) the DON/designee re-educated LPN (Licensed Practical Nurse) #3 on hand hygiene. 2. Those who reside in the facility have the potential to be affected by this alleged deficient practice. The DON/designee observed a medication administration pass to ensure hand hygiene was performed. 3. The DON/designee re-educated the licensed nurses on the facility's hand hygiene policy 4. The DON or designee to conduct QI monitoring via observations to ensure hand hygiene is performed during medication pass. QI monitoring to be completed 2 times a week for 4 weeks using a sample size of 3 nurses. Findings to be reviewed during the QAPI Committee Meeting and updated as indicated. QI schedule modified based on findings.	3-08-23

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F 880	Continued From page 21 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to perform hand hygiene during a medication pass on one of two units (East). The findings include: During a medication pass on the East unit, a nurse failed to perform hand hygiene after gloves changes and between contact with residents' personal items. A medication pass observation was conducted on 2/1/23 at 8:07 a.m. with licensed practical nurse (LPN) #3. Without performing hand hygiene, LPN #3 put on gloves and prepared medicines for the first resident in the medication pass observation (Resident #47). LPN #3 touched Resident #47's cup of water and then discarded the empty medicine cup after the resident was administered the oral medicines. LPN #3 then removed/discarded the gloves and without hand hygiene, put on a clean pair of gloves. LPN #3	F 880		

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F 880	Continued From page 22 then filled the roommate's cup of water, touching the cup, top, and straw. LPN #3 removed/discarded the gloves after handling the resident's cup and then left the resident's room. Without performing hand hygiene, LPN #3 put on clean gloves and prepared medications for Resident #50. LPN #3 administered the oral medications to Resident #50 handling the resident's cup, medicine cup and bed table. LPN #3 removed her gloves and returned to the medication cart. LPN #3 performed no hand hygiene between contact with residents' personal items, used medicine cups or between glove changes. On 2/1/23 at 8:21 a.m., LPN #3 was interviewed about the lack of hand hygiene observed during the medication pass. LPN #3 stated that she was supposed to use hand sanitizer or wash hands between contact with residents or their personal items. LPN #3 stated she was "nervous" and "wasn't thinking" when she omitted the hand hygiene. LPN #3 stated hand sanitizer was available on her cart and in each resident room. On 2/2/23 at 8:30 a.m., the infection preventionist (LPN #2) was interviewed about requirements for hand hygiene when preparing and/or administering medications. LPN #2 stated that nurses were supposed to wash or sanitize their hands prior to preparing medications and between contacts with residents or any of their personal items. Questioned further, LPN #2 stated that hand hygiene was required after glove removal. The facility's policy titled Handwashing/Hand Hygiene (revised August 2019) documented, "This facility considers hand hygiene the primary	F 880		

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F 880	Continued From page 23 means to prevent the spread of infections...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...Use an alcohol-based hand rub...or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations...Before and after direct contact with residents...Before preparing or handling medications...After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident...After removing gloves..." This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/1/23 at 4:15 p.m. No additional information was presented.	F 880		