STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(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 02/21/2023 through 02/23/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.	
F 000	INITIAL COMMENTS An unannounced onsite Medicare/Medicaid standard survey was conducted 02/21/2023 through 02/23/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two (2) complaints were investigated during the survey: VA00054019: Four allegations: All unsubstantiated VA00053885: Five allegations: Allegations #1, 2, 3, and 5 - were unsubstantiated. Allegation #4 was substantiated without deficient practice identified. The census in this 93 certified bed facility was 78 at the time of the survey. The survey sample consisted of sixteen (16) current Resident reviews and three (3) closed record reviews.	F 000		
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:	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Ham — TITLE: Administrator — (X6) DATE: 4/5/23

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 658	Continued From page 1 Based on resident interview, staff interview, clinical record review, and facility document review the facility staff failed to follow professional standards of practice during medication administration for one of 19 residents in the survey sample: Resident # 33. Findings include: Resident # 33 was admitted to the facility 2/20/20 with diagnoses to include, but were not limited to: end stage renal disease, heart disease, high blood pressure, and insomnia. The most recent MDS (minimum set) was quarterly assessment dated 1/15/23. Resident # 33 was assessed as cognitively intact with a total summary score of 15/15. On 2/21/23 beginning at approximately 3:00 p.m. during review of the clinical record, a nurses note dated 2/15/23 at 3:48 p.m. documented "Resident was given the medication of another resident by mistake. Medication was Bethanechol (helps with urination)10 mg, Xanax (anti-anxiety) 0.5 mg, Cipro (antibiotic) 500 mg, Iron 325 mg, Fluvoxamine (antidepressant) 50 mg, Gabapentin (anticonvulsant) 200 mg, Lisinopril (for high blood pressure), Metformin (lowers blood sugars) 500 mg, Probiotic, and Senna 8.6. NP was notified and neuro checks were ordered every 15 minutes for one hour and then every hour for 4 hours. Then vital signs every 4 hours x 3. Resident had no issues after this medication was given. His vital signs as well as neuro checks have all been within normal limits. Resident is aware of the situation."	F 658	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. F 658 1. Resident #33 had a pharmacy review and receives medication per Physician order. Resident had no adverse effects from medication error. 2. Medication pass observations were completed on licensed nurses. 3. DON/Designee re-educated licensed nurses on the eight rights of medication administration. Medication administration audits will be conducted 3x a week for 4 weeks.	

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F 658	Continued From page 2	F 658		

On 2/21/23 at approximately 3:30 p.m. the DON (director of nursing) was asked if there was an investigation for the medication error. She stated there was. She was asked to see it, and she stated she would get it to me.

On 2/22/23 at approximately 9:30 a.m. Resident # 33, who had just returned from dialysis, was asked about the incident. Resident # 33 stated "Yes; I was sitting in my doorway and the nurse came down the hall and handed me a cup of medicines. Then she came back and said she made a mistake and gave me the wrong medicines and then she gave me my medicines. I was alright though....."

On 2/22/23 at approximately 10:00 a.m. the facility's nurse practitioner (NP) was interviewed. She stated "I was notified no more than 15 minutes after it happened. I was already in-house. I went to talk to the nurse; went to patient's room and saw him fact-to-face 30-45 minutes after he got the meds.....any sooner would not have had time for any effect....he was tired, fatigued, and drowsy, so they had started to take effect. The main concern was Xanax and Gabapentin; even though he isn't a diabetic Metformin does not have a big impact on blood sugars so we did not check his blood sugars. I then gave the orders you see for the neuro checks and vital signs. The resident did not have any adverse event from the incident."

On 2/22/23 at approximately 10:50 a.m. the nurse who administered the medications was contacted by phone. RN (registered nurse) # 1 was interviewed about the medication error. RN # 1 stated "I had gotten his medications ready, but he

4. Audits will be reviewed in QAPI and any discrepancies will be corrected immediately. Re-education will be provided as needed.

5. Date of compliance is March 23, 2023.

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F 658	Continued From page 3	F 658		

wasn't ready to take them so I put the cup in the medication cart drawer. I started working on another resident's medications, and in the middle of that (name of Resident # 33) came to the med cart for his meds. I got the cup of pills from the cart and set it on top of the cart. He had just gotten back from dialysis, and we always take his blood pressure and vitals when he gets back, so I took his vitals, picked up the cup of pills I thought was his,and gave them. I even had his initials on the cup but still picked up the wrong one. I immediately notified the unit manager, and we did a medication incident form....."

On 2/22/23 at approximately 11:15 a.m., the DON, administrator, unit manager, and regional nurse were interviewed about the incident, and asked for the facility policy for medication administration. The unit manager, LPN (licensed practical nurse) # 2 stated, "I did do verbal education on medication administration after the incident for RN # 1..."

On 2/22/23 at approximately 11:30, the medication incident form was reviewed as filled out by RN # 1. The form identified Resident # 33 and the date of the incident of 2/15/23. The form included the medications that had been administered in error to Resident # 33, and under "Explanation" RN # 1 had documented " Resident came up to have his medicine given. There was another med cup sitting on top of the cart that had just been pulled. Wrong cup was picked up and given."

The facility policy "Medication Administration General Guidelines" directed "1. Medications are administered in accordance with written orders of the presciber..... 4. Medications are to be

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F 658	Continued From page 4 administered at the time they are prepared. ....9. Verify medication is correct three (3) times before administering medication (a) When pulling medication from med cart (b) When dose is prepared (c) Before dose is administered..... 16. Medications supplied for one resident are never administered to another resident..... 17. During administration of medications, the medication cart is kept closed and locked.....No medications are kept on top of cart." On 2/23/23 beginning at approximately 12:50 p.m., the administrator, DON, LPN # 2, and regional nurse were informed of the above findings. No further information was provided prior to the exit conference.	F 658		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than 5 percent. The facility had two medication errors out of 28 medication opportunities, which resulted in a medication error rate of 7.14 percent. Findings include:	F 759	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.	

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F 759	Continued From page 5 On 02/22/23 at 8:29 AM, a medication pass and pour observation was completed with Licensed Practical Nurse (LPN) #1. LPN #1 prepared medications for Resident #35, which included Vitamin C 500 milligrams (mg) (one tablet), Ferrous Sulfate 325 /65 mg (one tablet), Losartan Potassium 100 mg (one tablet), Miralax 17 grams (mixed with water) and Pravastatin Sodium Tablet 40 MG (one tablet). The resident had a total of 4 tablets and the Miralax mixture. The LPN administered the medication to Resident #35. At approximately 9:45 AM, a medication reconciliation was completed for Resident #35. The resident's physician's orders revealed the resident had an order for Protonix 40 mg once daily. The Protonix 40 mg was ordered on 02/21/23 and was ordered to start on 02/22/23. LPN #1 did not administer Protonix 40 mg to Resident #35 during the medication pass and pour observation. The resident's physician orders did not show a current order for the medication Pravastatin Sodium Tablet 40 MG. Further review of the resident's physician's orders revealed that the Pravastatin Sodium Tablet 40 MG had been discontinued for Resident #35 on 02/09/23. On 02/22/23 at 10:42 AM, LPN #1 was asked to pull up the resident's MAR (medication administration records) and to pull medication cards from the med cart for Resident #35. The LPN pulled out the medication cards, including the medication card for the Pravastatin 40 mg.	F 759	F 759 1. Facility failed to ensure medication errors were below 5%. 2. Medication pass observations were completed on licensed nurses. 3. DON/Designee re-educated licensed nurses on the eight rights of medication administration. Medication pass observations will be completed for 4 weeks. 4. Audits will be reviewed in QAPI and any discrepancies will be corrected immediately. Re-education will be provided as needed. 5. Date of compliance is March 23, 2023.	

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The LPN was made aware that she did not give the ordered Protonix 40 mg, the LPN stated this is it and pointed to the Pravastatin 40 mg card. The LPN then stated, "I gave her the wrong thing." "I made a med error." The medication Pravastatin 40 mg (the discontinued medication) was given instead of Protonix 40 mg (ordered medication). The LPN stated she didn't understand why that medication (the discontinued medication) was still in the medication cart. The LPN was then asked if the medication Protonix 40 mg was available for administration. The LPN looked again in the medication cart and found the card for the Protonix. The LPN was made aware that the medication observation had resulted in two medication errors, the wrong medication (discontinued medication) was administered and the medication that was ordered was not given and was omitted.

On 02/22/23 at 11:13 AM, the nurse consultant, administrator and DON (director of nursing) were made aware of the above information in a meeting with the survey team. The facility staff were asked for a policy on medication administration.

The facility's policy titled, "Medication Administration General Guidelines" documented, "...Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices...prior to administration, review and confirm medication orders for each individual resident...compare the medication and dosage schedule on the resident's MAR with the medication label...medications are administered in accordance with written orders of the prescriber...Verify medication is correct three (3)

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F 759	Continued From page 7 times before administering the medication...When pulling medication package from med cart...when dose is prepared...before dose is administered..." No further information and/or documentation was presented prior to the exit conference on 02/23/23 at 1:30 PM.	F 759	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review the facility staff failed to ensure one of 19 residents in the survey sample was free from a significant medication error: Resident # 33. Findings include: Resident # 33 was admitted to the facility 2/20/20 with diagnoses to include, but were not limited to: end stage renal disease, heart disease, high blood pressure, and insomnia. The most recent MDS (minimum set) was quarterly assessment dated 1/15/23. Resident # 33 was assessed as cognitively intact with a total summary score of 15/15. On 2/21/23 beginning at approximately 3:00 p.m. during review of the clinical record, a nurses note dated 2/15/23 at 3:48 p.m. documented "Resident was given the medication of another resident by	F 760	F 760 1. Resident #33 had pharmacy review and is receiving medications per physician orders. Resident had no adverse effects from medication error. 2. Medication pass observations were completed on licensed nurses. 3. DON/Designee re-educated licensed nurses on the eight rights of medication administration. Medication pass observations will be completed for 4 weeks.	

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F 760	Continued From page 8	F 760	4. Audits will be reviewed in QAPI and any discrepancies will be corrected immediately. Re-education will be provided as needed. 5. Date of compliance is March 23, 2023.	

mistake. Medication was Bethanechol (helps with urination)10 mg, Xanax (anti-anxiety) 0.5 mg, Cipro (antibiotic) 500 mg, Iron 325 mg, Fluvoxamine (antidepressant) 50 mg, Gabapentin (anticonvulsant) 200 mg, Lisinopril (for high blood pressure), Metformin (lowers blood sugars) 500 mg, Probiotic, and Senna 8.6. NP was notified and neuro checks were ordered every 15 minutes for one hour and then every hour for 4 hours. Then vital signs every 4 hours x 3. Resident had no issues after this medication was given. His vital signs as well as neuro checks have all been within normal limits. Resident is aware of the situation."

On 2/21/23 at approximately 3:30 p.m. the DON (director of nursing) was asked if there was an investigation for the medication error. She stated there was. She was asked to see it, and she stated she would get it to me. The DON returned a few minutes later and stated there had been a medication incident form completed, and a check sheet. She was then asked for a copy of the documentation.

On 2/22/23 at approximately 8:45 a.m. the DON presented the requested information, as well as a copy of the facility medication administration policy.

On 2/22/23 at approximately 9:30 a.m. Resident # 33, who had just returned from dialysis, was asked about the incident. Resident # 33 stated "Yes; I was sitting in my doorway and the nurse came down the hall and handed me a cup of medicines. Then she came back and said she made a mistake and gave me the wrong medicines and then she gave me my medicines. I was alright though....."

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F 760	Continued From page 9	F 760		

On 2/22/23 at approximately 10:00 a.m. the facility's nurse practitioner (NP) was interviewed. She stated "I was notified no more than 15 minutes after it happened. I was already in-house. I went to talk to the nurse; went to patient's room and saw him fact-to-face 30-45 minutes after he got the meds.....any sooner would not have had time for any effect....he was tired, fatigued, and drowsy, so they had started to take effect. The main concern was Xanax and Gabapentin; even though he isn't a diabetic Metformin does not have a big impact on blood sugars so we did not check his blood sugars. I then gave the orders you see for the neuro checks and vital signs. The resident did not have any adverse event from the incident."

On 2/22/23 at approximately 10:50 a.m. the nurse who administered the medications was contacted by phone. RN (registered nurse) # 1 was interviewed about the medication error. RN # 1 stated "I had gotten his medications ready, but he wasn't ready to take them so I put the cup in the medication cart drawer. I started working on another resident's medications, and in the middle of that (name of Resident # 33) came to the med cart for his meds. I got the cup of pills from the cart and set it on top of the cart. He had just gotten back from dialysis, and we always take his blood pressure and vitals when he gets back, so I took his vitals, picked up the cup of pills I thought was his,and gave them. I even had his initials on the cup but still picked up the wrong one. I immediately notified the unit manager, and we did a medication incident form....." RN # 1 was asked if she had received any education following the incident, and if she had continued to give

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medications the rest of the shift. RN # 1 stated "Yes, that happened around 10 or so in the morning. I finished my shift, and then was off 2/16/23 and 2/17/23. I came back to work 2/18/23 and worked that day, and 2/19/23, and 2/20/23. The unit manager came to me with education on medication administration, and I signed off on the policy....I'm not positive a med pass observation being done with me....."

On 2/22/23 at approximately 11:15 a.m. the DON, administrator, unit manager, and regional nurse were interviewed about the incident, and asked for the facility policy for medication administration. The unit manager, LPN (licensed practical nurse) # 2 stated "I did do verbal education on medication administration after the incident for RN # 1.....I don't have anything written." LPN # 2 confirmed RN # 1 stayed on the med cart until 7 p.m. on 2/15/23, was off 2/16/23 and 2/17/23, came back to work and gave meds 2/18/23, 2/19/23, and the morning of 2/20/23. The medication administration policy, which RN # 1 and LPN # 2 identified as the formal education piece was dated and signed by RN # 1 on 2/20/23. When asked about any reporting of the incident and for the complete investigation, the DON stated there was no investigation on paper. The administrator stated "There was no harm to the resident so no reporting was done."

On 2/22/23 at approximately 11:30 the medication incident form was reviewed as filled out by RN # 1. The form identified Resident # 33 and the date of the incident of 2/15/23. The form included the medications that had been administered in error to Resident # 33, and under "Explanation" RN # 1 had documented " Resident came up to have his medicine given. There was another med cup

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sitting on top of the cart that had just been pulled. Wrong cup was picked up and given."

The facility policy "Medication Administration General Guidelines" directed "1. Medications are administered in accordance with written orders of the presciber..... 4. Medications are to be administered at the time they are prepared. ....9. Verify medication is correct three (3) times before administering medication (a) When pulling medication from med cart (b) When dose is prepared (c) Before dose is administered..... 16. Medications supplied for one resident are never administered to another resident..... 17. During administration of medications, the medication cart is kept closed and locked.....No medications are kept on top of cart."

On 2/23/23 beginning at approximately 11:30 a.m. the administrator, DON, LPN # 2, and regional nurse were informed of the above findings.

No further information was provided prior to the exit conference.

F 842 SS=D Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

F 842

§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.

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F 842	Continued From page 12 §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 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	F 842	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. F 842 1. Resident #33 records reviewed for completion and accuracy. 2. Resident's that requires neuro checks will have them completed. 3. DON/Designee re-educated licensed nurses on completing neuro checks. Audits on neuro checks will be completed for 4 weeks. 4. Audits will be reviewed in QAPI and any discrepancies will be corrected immediately. Re-education will be provided as needed. 5. Date of compliance is March 23, 2023.	

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(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 resident interview, staff interview, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of 19 residents in the survey sample: Resident # 33.

Findings include:

Resident # 33 was admitted to the facility 2/20/20 with diagnoses to include, but were not limited to, end stage renal disease, heart disease, high blood pressure, and insomnia.

The most recent MDS (minimum set) was quarterly assessment dated 1/15/23. Resident # 33 was assessed as cognitively intact with a total summary score of 15/15.

On 2/21/23 beginning at approximately 3:00 p.m. during review of the clinical record, a nurses note dated 2/15/23 at 3:48 p.m. documented "Resident

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was given the medication of another resident by mistake. Medication was Bethanechol (helps with urination)10 mg, Xanax (anti-anxiety) 0.5 mg, Cipro (antibiotic) 500 mg, Iron 325 mg, Fluvoxamine (antidepressant) 50 mg, Gabapentin (anticonvulsant) 200 mg, Lisinopril (for high blood pressure), Metformin (lowers blood sugars) 500 mg, Probiotic, and Senna 8.6. NP was notified and neuro checks were ordered every 15 minutes for one hour and then every hour for 4 hours. Then vital signs every 4 hours x 3. Resident had no issues after this medication was given. His vital signs as well as neuro checks have all been within normal limits. Resident is aware of the situation."

On 2/22/23 at approximately 9:30 a.m. Resident # 33, who had just returned from dialysis, was asked about the incident. Resident # 33 stated, "Yes, I was sitting in my doorway and the nurse came down the hall and handed me a cup of medicines. Then she came back and said she made a mistake and gave me the wrong medicines and then she gave me my medicines. They took my blood pressure a couple of times.....I was alright though....."

On 2/22/23 at approximately 10:00 a.m. the facility's nurse practitioner (NP) was interviewed. She stated, "I was notified no more than 15 minutes after it happened. I was already in-house. I went to talk to the nurse; went to patient's room and saw him fact-to-face 30-45 minutes after he got the meds.....any sooner would not have had time for any effect....he was tired, fatigued, and drowsy, so they had started to take effect. The main concern was Xanax and Gabapentin; even though he isn't a diabetic Metformin does not have a big impact on blood

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sugars so we did not check his blood sugars. I then gave the orders you see for the neuro checks and vital signs." The NP was asked if it was known where the documentation for the neuro checks and vital signs were, as the current MAR (medication administration record) and TAR (treatment administration record) included the orders, but there were no staff initials to document the checks and vitals were done. The NP reviewed the record and stated, "I don't know what was done on here; there's no documentation. Looks like there were 2 sets of vital signs done; there should have been 4.....there's nothing for the neuro checks..."

On 2/22/23 at approximately 10:50 a.m., the nurse who administered the medications was contacted by phone. RN (registered nurse) # 1 was interviewed about the medication error. RN # 1 stated, "I had gotten his medications ready, but he wasn't ready to take them so I put the cup in the medication cart drawer. I started working on another resident's medications, and in the middle of that (name of Resident # 33) came to the med cart for his meds. I got the cup of pills from the cart and set it on top of the cart. He had just gotten back from dialysis, and we always take his blood pressure and vitals when he gets back, so I took his vitals, picked up the cup of pills I thought was his,and gave them. I even had his initials on the cup but still picked up the wrong one. I immediately notified the unit manager, and we did a medication incident form....." RN # 1 was asked where the documentation for the vital signs were, as well as the neuro checks. She stated "We did the vital signs and neuro checks; it's on a form that I turned in to the unit manager...."

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F 842	Continued From page 16 On 2/22/23 at approximately 11:15 a.m., the DON, administrator, unit manager, and regional nurse were interviewed about the incident. The unit manager, LPN (licensed practical nurse) # 2 was asked about the documentation for the vital signs and neuro checks that was turned in to her. LPN #2 stated she did not receive the documentation. The DON (director of nursing) added, "[name of RN # 1] says she did the neuro checks, but we don't have anything that substantiates they were done.....that includes the vital signs." On 2/23/23 beginning at approximately 12:50 p.m., the administrator, DON, LPN # 2, and regional nurse were informed of the above findings. No further information was provided prior to the exit conference.	F 842	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.	
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.	F 847	F 847 1. Resident #43 received an updated Arbitration Agreement. 2. Residents admitted after October 24, 2022 received new arbitration agreements and were granted extension of 30 days.	

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F 847	Continued From page 17 §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the proper timeframe was in place to rescind a binding arbitration agreement for residents in the facility.	F 847	3. Senior Vice President of Business Development re-educated the Administrator and Director of Admissions and Marketing. Residents admitted after February 27, 2023 received updated arbitration agreements. New admissions will be audited weekly to ensure updated arbitration agreement completed. 4. Audits will be reviewed in QAPI and any discrepancies will be corrected immediately. Re-education will be provided as needed. 5. Date of compliance is March 23, 2023.	

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Findings were:

During the entrance conference on 02/21/2023 at approximately 1:00 p.m., the administrator was asked if residents or his/her representatives were asked to enter into a binding arbitration agreement with the facility. She responded, "Yes." A copy of the facility arbitration agreement was requested.

On 02/23/2023 at approximately 9:45 a.m., the "VOLUNTARY ARBITRATION AGREEMENT PROGRAM GUIDE" was reviewed and contained the following process listed under ARBITRATION PROCEDURES: "If you sign the Agreement and later change your mind, you will have ten (10) business days from the date of execution of the Agreement to completely cancel and void the Agreement."

Further review of the "VOLUNTARY ARBITRATION AGREEMENT included the following: "Right to Change Your Mind: The resident will receive from the Facility a copy of this agreement upon it being fully executed. This Agreement may be canceled via a written notice sent to the Facility administrator by certified mail, return receipt requested, within ten (10) business days of the date is is executed by the Resident." On the last page of the Agreement was a signature page with four bullets to be checked off the by the resident. The fourth bullet was : "The Resident is aware that he/she may rescind this Agreement at any time within ten (10) business days of the date of its execution."

The administrator was interviewed on 02/23/2023 at approximately 10:00 a.m. regarding the timeframe listed on the Agreement for residents

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F 847	Continued From page 19 to rescind their decision to enter the agreement. She stated she would look into it. At approximately 11:00 a.m., the administrator stated, "We will be making changes to the Arbitration Agreement about the timeframe for the residents to rescind their decision." No further information was obtained prior to the exit conference on 02/23/2023.	F 847	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	F 880 1. Licensed nurses re-educated on hand washing techniques during medication pass observation with residents 9, 35, and 67. 2. Licensed nurses will demonstrate handwashing during medication pass observations.	

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F 880	Continued From page 20 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 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.	F 880	3. DON/designee re-educated licensed nurses on handwashing during medication administration. Audits will be completed to observe for handwashing compliance during medication administration for 4 weeks. 4. Audits will be reviewed in QAPI and any discrepancies will be corrected immediately. Re-education will be provided as needed. 5. Date of compliance is March 23, 2023.	

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F 880	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview, and facility document review, the facility staff failed to ensure infection control practices during the administration of medications. Findings include: On 02/22/23 at 8:29 AM, a medication pass and pour observation was conducted with LPN (Licensed Practical Nurse) #1. The LPN did not wash or sanitize her hands prior to preparing medications for Resident #67. The LPN prepared and administered the medications to Resident #67, left the resident's room and immediately began to prepare Resident #35. The LPN did not wash and/or sanitize her hands before proceeding to the next resident. LPN #1 prepared Resident #35's medications and administered the medications to the resident. LPN #1 left the resident's room, did not wash and/or sanitizer her hands and immediately began to prepare medications for Resident #9. LPN #1 prepared and administered medications to Resident #9, exited the room and then retrieved the hand sanitizer on the medication cart to cleanse her hands. At this time (8:53 AM), LPN #1 was made aware that she did not sanitize her hands at all between the residents' observed for the medication pass and pour observation (as described above). LPN #1 stated, "I just realized that." The LPN sanitized her hands at that time.	F 880		

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On 02/22/23 at 11:13 AM, the nurse consultant, the DON (director of nursing) and the administrator were made aware of the above information in a meeting with the survey team. The facility staff were asked for a policy on handwashing practices.

The policy presented titled, "Medication Administration General Guidelines" documented, "...Hands are washed with soap and water again after administration and with any resident contact...anti-microbial sanitizer may be used in place of soap and water as allowed by state nursing regulations and facility policy..."

The policy presented titled, "Policies and Procedures Handwashing Technique" documented, "All personnel will wash hands before beginning the treatment/care of a resident and upon completion of such tasks, to prevent the spread of nosocomial infections..."

No further information and/or documentation was presented prior to the exit conference on 02/23/23 at 1:30 PM.