STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING ______ B. WING ______	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 05/08/23 through 05/10/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Six complaints were investigated during the survey (VA00058091-substantiated with deficiency, VA00058613-substantiated with deficiency, VA00058797-substantiated with deficiency, VA00058773-substantiated with deficiency, VA00058763-substantiated with deficiency and VA00058317-substantiated with deficiency). The census in this 225 certified bed facility was 197 at the time of the survey. The survey sample consisted of 10 resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 600	Past noncompliance: no plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/22/2023

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 600	Continued From page 1	F 600		

facility document review and clinical record review it was determined that the facility failed to protect one of ten residents in the survey sample from misappropriation of property.

correction required.

The findings include:

For Resident #7 (R7), the facility staff failed to protect the resident from misappropriation of property. On 2/13/2023 R7's Rolex watch was discovered to be missing.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 5/8/2023 at 3:30 p.m., an interview was conducted with R7 in their room. R7 stated that their Rolex watch was missing. R7 stated that they had gone to bed with the watch on their wrist and woke up the next morning with it gone. R7 stated that they had reported the watch missing to the nursing supervisor that Sunday and they had searched the room and could not find it. R7 stated that the therapist had also searched the room and could not find it. R7 stated that on Monday evening the facility contacted the police for them and they came to take statements. R7 stated that the nurses aide who worked with them Saturday evening had stated that when they took their jacket off the watch had fallen off of their wrist and they had put it on the nightstand. R7 stated that the watch had not fallen off because of the double clasp on it and they would have remembered it falling off. R7 stated that the facility had sent the nurses aide home until the

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F 600	Continued From page 2	F 600		

investigation was completed because he was the last one to have seen the watch. R7 stated that the investigation was still going on with the police but they were not hopeful that they would get it back. R7 stated that they had not seen the nurses aide back in the facility since that Monday.

The facility synopsis of events dated 2/13/2023 documented in part, "...On Feb. 12, 2023, (Name of R7) reported to staff that his gold Rolex watch was missing. (Name of R7) remembers wearing the watch to bed on the night of Feb. 11, 2023, but when he awoke on the next morning, the watch was missing from his left wrist. RP (responsible party) and Law Enforcement notified. Investigation initiated..." The final report of the event dated 2/17/2023 documented in part, "...Based on investigation and findings the allegation of misappropriation of property is substantiated. The investigation against (Name of CNA (certified nursing assistant) #7) remains on-going with Law Enforcement. (Name of CNA #7) is no longer employed with the facility. The staff will receive education on the abuse policy regarding misappropriation of property..."

Review of the employee record for CNA #7 documented they were hired as a TNA (temporary nursing assistant) beginning on 5/3/2022. Review of the file revealed a Virginia State Police background check completed prior to employment, reference checks and a signed sworn statement by the applicant.

Review of staff educational sign-in sheets for the abuse and how to report abuse inservice dated 2/17/2023-2/22/2023 documented 73 staff members educated. A nine page power point presentation "What is Abuse?" was attached to

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F 600	Continued From page 3 the education sign-in sheets with the facility policy. Abuse education and training was reviewed and verified by multiple staff interviews. Implementation of the education was verified with resident interviews and observations. No concerns were identified. On 5/9/2023 at 12:31 p.m., an interview was conducted with ASM (administrative staff member) #4, assistant director of nursing. ASM #4 stated that R7's watch went missing over a weekend and they were notified on Monday. ASM #4 stated that they contacted the policy who came in to file a report. ASM #4 stated that the resident had reported that they had started feeling bad on 2/11/2023 and had gone to bed early. ASM #4 stated that the CNA had put him to bed early and he did not remember the watch falling off and he woke up the morning with it gone. ASM #4 stated that they interviewed CNA #7 because they were the person who put R7 to bed and CNA #7 told them the watch had come off when they were putting R7 in the bed and they had picked it up and put it on the nightstand. ASM #4 stated that they interviewed the night shift CNA who stated that R7 had slept all night and had not even gotten up to go to the restroom. ASM #4 stated that the night CNA stated that they had looked in on R7 but had not noticed a watch. ASM #4 stated that when the day shift CNA went in Sunday morning and R7 woke up they noticed the watch was gone. ASM #4 stated that they searched the room and could not find the watch. ASM #4 stated that at that point they identified CNA #7 as the last person to see the watch so the police came in to interview him and then he was suspended. ASM #4 stated that the police investigation was still ongoing. ASM #4 stated that their investigation was completed and they	F 600		

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F 600	Continued From page 4	F 600		

had terminated CNA #7 based on him having the last contact with the watch. ASM #4 stated that they did not want people in their facility that were thieves however they could not prove that he did it. ASM #4 stated that R7 would know if the watch came off and they said it did not happen. ASM #4 stated that they had completed education after this incident, that staff were educated upon hire and staff are retrained annually. ASM #4 stated that R7 was a victim of misappropriation. ASM #4 stated that their date of compliance for the misappropriation training was when their education was completed 2/22/2023 and monitoring was ongoing. ASM #4 stated that the supervisors rounded with residents and encouraged residents to send any high dollar items home. No additional concerns regarding misappropriation of resident property was identified while on survey.

On 5/9/2023 at 1:55 p.m. an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that they had spoken to R7 on 2/12/2023 when they reported the watch missing. LPN #7 stated that R7 reported that it was missing and was worth a substantial amount of money. LPN #7 stated that they searched the room and interviewed two CNA's. LPN #7 stated that they interviewed the evening CNA that day and they had not worked with R7 on 2/11/2023 and they also interviewed CNA #7. LPN #7 stated that CNA #7 told them that they had taken R7's shirt off when getting them ready for bed and the watch came off and fell on the floor. LPN #7 stated that CNA #7 told them they had put the watch on the bedside table. LPN #7 stated that they had searched the room and the laundry and could not find the watch so they had reported the missing watch to the director of nursing and

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F 600	Continued From page 5 written the missing watch on the supervisor report. LPN #7 stated that they did not contact the police on 2/12/2023, that the administrative team did the next day. The facility policy "Abuse/Neglect/Misappropriation/Crime" dated 11/1/19 documented in part, "A licensed nurse will immediately respond to all allegations and/or reasonable suspicions of staff to patient, patient to patient, and/or visitor to patient, abuse, neglect, mistreatment, exploitation or any misappropriation of patient property or crime against a patient..." On 5/10/2023 at 4:25 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were notified of the findings. No further information was provided prior to exit. Past non-compliance.	F 600		
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 staff interview, clinical record review and facility document review, it was determined the facility staff failed to complete an accurate MDS (minimum data set) assessment for one out of 10 residents in the survey sample, Residents	F 641	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following	5/31/23

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F 641

Continued From page 6
#2.

The findings include:

The facility staff failed to complete an accurate annual assessment MDS (minimum data set) for Resident #2, to include the use of a wanderguard.

Resident #2 was admitted to the facility on 3/22/23 with diagnoses that included but were not limited to: dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/10/23, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. Section P-Restraints and Alarms P.0200 E. coded the resident as "wander / elopement alarm-not used."

A review of the comprehensive care plan dated 3/22/23, revealed, "FOCUS: The resident is at risk for elopement related to confusion and disorientation, exit seeking. INTERVENTIONS: Check placement and function every shift. Elopement risk assessment as needed. Replace elopement band as needed. Wander guard to left ankle."

On 5/8/23 at 10:30 AM, Resident #2 was observed with wander guard to left ankle.

A review of physician orders, dated 3/22/23, revealed the following, "Check Wander Prevention patient Band every shift. Check Wander Prevention System Function Every Week-every Sunday."

F 641

plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F641 Accuracy of Assessments
1. Resident #2 MDS coding was revised to reflect wanderguard on 5/9/2023.
2. Current residents in the facility have the potential to be affected. MDS staff conducted an audit to verify residents with wanderguards have accurate coding on the MDS assessment.
3. The Regional Director of MDS or designee will educate the MDS staff on the process for accurate coding on all MDS assessments for residents with wander guards,
4. The MDS staff or designee will complete weekly audits x 4 weeks then monthly x 2 months to verify MDS coding is accurate on MDS assessments for residents with wanderguards. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist, the review will be conducted on a random basis.
5. Date of compliance 5/31/2023.

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F 641	Continued From page 7 On 5/9/23 at 10:00 AM, an interview was conducted with OSM (other staff member) #5, the MDS coordinator. OSM #5 was asked to verify the coding Resident #2's wander guard in Section P for the 4/10/23. On 5/9/23 at 12:40 PM, OSM #5 stated, "We had an agency MDS coordinator and she did not code it correctly. [The resident] does have a wander guard. We have submitted the modification." When asked what standard is followed for completing the MDS, OSM #5 stated the RAI (resident assessment instrument). On 5/9/23 at approximately 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #4, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit.	F 641		
F 656 SS=E	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	F 656		5/31/23

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F 656	Continued From page 8 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 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 resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for seven of ten	F 656	F656 Develop/Implement Comprehensive Care Plan 1. Resident #3 no longer resides in the facility. Resdient#8 no longer resides in the	

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residents in the survey sample, Residents #3, #8, #6, #9, #1, #2, and #4.

The findings include:

1. For Resident #3 (R3), the facility staff failed to implement the care plan to administer pain medication as ordered.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section J documented R3 having pain frequently.

The comprehensive care plan for R3 documented in part, "PAIN: [Name of R3] has potential for Pain related to disease process, impaired mobility. Created on: 03/30/2022, Revision on: 03/30/2022." Under "Interventions" it documented in part, "...Administered [sic] pain medication per physician orders Created on: 03/30/2022." The care plan further documented, "CARE NEEDS: [Name of R3] has the following care needs: cervical spinal cord injury, quadriplegia, asthma, fall and posthemorrhagic anemia. Created on: 03/30/2022." Under "Interventions" it documented in part, "Administer medications and/or treatments as ordered. Created on: 03/30/2022..."

The physician orders for R3 documented in part,
- "Baclofen (1) Tablet 10 MG (milligram) Give 3 tablet by mouth four times a day for Muscle Spasms. May cause drowsiness, avoid alcohol. Order Date: 03/28/2022."

F 656

facility.
Resident# 6 care plan was revised on 5/12/23 to reflect current wounds.
Resident #9 care plan was revised on 5/10/23 to current IV access interventions.
Resident # 1 no longer resides in the facility.
Resdient#2. care plan for wanderguard with documentation is being followed.
Resident #4 care plan for ADL interventions for incontinent care, personal hygiene and dressing is being followed with documentation.

2. Current residents in the facility have the potential to be affected. An audit was conducted by the DON or designee to verify current residents care plan reflect wounds, IV accesses, inotropic therapy, and verify residents care plan interventions for ADLs incontinent care, personal hygiene and dressing and residents with wander guard and pain management was followed with documentation.

3. The Regional Director of MDS or designee will educate the MDS staff and nursing management (DON, ADON, Unit Managers and Supervisors) on the process for resident□s care plan are initiated and implemented to reflect and meet the needs of the resident□s condition and care and followed and documentation is complete. The Staff Development Coordinator or designee will educate all the licensed nurses on the process for resident□s care plan are initiated and implemented to reflect and meet the needs of the resident□s condition and care and followed and

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- "Gabapentin (2) Tablet 600 MG Give 1 tablet by mouth three times a day for Pain. Order Date: 03/28/2022."
- "tizanidine HCl (3) Tablet 4 MG Give 1 tablet by mouth three times a day for muscle spasms. Order Date: 04/13/2022."

Review of the eMAR (electronic medication administration record) dated 7/1/2022-7/31/2022 documented the Baclofen 10 mg scheduled daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. The Gabapentin 600 mg was scheduled daily at 9:00 a.m., 1:00 p.m., and 5:00 p.m. The tizanidine HCL 4 mg was scheduled daily at 6:00 a.m., 2:00 p.m., and 10:00 p.m.

Review of the Medication admin (administration) Audit report dated 7/1/2022-7/31/2022 documented:
The Baclofen 10 mg scheduled at 9:00 p.m. administered late on 7/3/2022 at 11:45 p.m., on 7/5/2022 at 11:06 p.m., on 7/7/2022 at 10:53 p.m., on 7/8/2022 at 11:59 p.m., on 7/10/2022 at 1:15 a.m., on 7/12/2022 at 11:19 p.m., on 7/13/2022 at 10:32 p.m., on 7/14/2022 at 12:02 a.m., and on 7/16/2022 at 10:41 p.m. The Baclofen 10 mg scheduled at 5:00 p.m. was administered late on 7/16/2022 at 8:14 p.m.
The Gabapentin 600 mg scheduled at 9:00 a.m. was administered late on 7/16/2022 at 1:27 p.m.
The Gabapentin 600 mg scheduled at 1:00 p.m. was administered late on 7/10/2022 at 2:37 p.m. and on 7/17/2022 at 2:44 p.m. The Gabapentin 600 mg scheduled at 5:00 p.m. was administered late on 7/3/2022 at 6:34 p.m., on 7/5/2022 at 6:29 p.m., on 7/17/2022 at 6:29 p.m., on 7/18/2022 at 7:36 p.m., on 7/27/2022 at 10:14 p.m., and on 7/29/2022 at 6:25 p.m.
The Tizanidine 4 mg scheduled at 6:00 a.m. was

F 656

documentation is complete.
4. The MDS staff or designee will audits weekly x 4 weeks then monthly x 2 months to verify 10 residents have a care plan initiated and implemented interventions for IV access, wounds/pressure ulcers, inotropic therapy. The UM or designee will audit weekly x 4 weeks then monthly x 2 months residents care plans for ADL incontinent care, personal hygiene and dressing, wander guards and pain management were followed with documentation in the clinical record. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis.
5. Date of compliance 5/31/2023.

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administered late on 7/4/2022 at 7:30 a.m., on 7/10/2022 at 7:53 a.m., on 7/19/2022 at 7:34 a.m., on 7/20/2022 at 7:19 a.m., and on 7/24/2022 at 7:52 a.m. The Tizanidine 4 mg scheduled at 2:00 p.m. was administered late on 7/16/2022 at 5:36 p.m. The Tizanidine 4 mg scheduled at 10:00 p.m. was administered late on 7/3/2022 at 11:46 p.m., 7/8/2022 at 11:59 p.m., 7/9/2022 at 1:15 a.m. (7/10/2022), on 7/13/2022 at 11:46 p.m., on 7/14/2022 at 12:02 a.m. (7/15/2022), on 7/19/2022 at 12:55 a.m. (7/20/2022), on 7/20/2022 at 12:44 a.m. (7/21/2022), on 7/21/2022 at 12:45 a.m. (7/22/2022), on 7/22/2022 at 12:51 a.m. (7/23/2022), on 7/23/2022 at 1:02 a.m. (7/24/2022), on 7/24/2022 at 11:21 p.m., on 7/28/2022 at 11:34 p.m., and on 7/29/2022 at 11:40 p.m.

The progress notes failed to evidence documentation regarding the late administration of the medications documented above.

On 5/10/2023 at 12:35 p.m., an interview was conducted with ASM (administrative staff member) #4, the assistant director of nursing. ASM #4 stated that the resident council had brought up concerns about timeliness of medications in the December meeting and they had wanted to know the timeframe before and after the scheduled time to get their medications. ASM #4 stated that they had discussed with the residents that the practice of an hour before and an hour after the scheduled time was within the range. When asked if any audits were performed on medication administration timeliness, ASM #4 stated that they would check. ASM #4 stated that the purpose of the care plan was to get an overall picture of the patient's care and should tell a story

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of why the resident was there. ASM #4 stated that they implemented the baseline care plan on admission and added things to it as they triggered. ASM #4 stated that the care plan was not being implemented if the treatments were not being followed per the doctors orders.

On 5/10/2023 at 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that medications were administered an hour before to an hour after the scheduled time. LPN #3 stated that they were administered in this window to keep the resident on a schedule and because of how the medications work. LPN #3 stated that when the medications were administered late the nurse should notify the physician and document it in the progress notes. LPN #3 stated the purpose of the care plan was to know the guideline of the resident's care and why they were in the facility. LPN #3 stated that the care plan started with the director of nursing and the managers. LPN #3 stated that the director of nursing, the managers and the nurses all reviewed and revised the care plans.

The facility policy "Care Planning" dated 11/01/19 documented in part, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient..."

On 5/10/2023 at 4:25 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4,

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assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

2. For Resident #8 (R8), the facility staff failed to develop a comprehensive resident centered care plan regarding a continuous intravenous cardiac medication infusion.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/19/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section O documented R8 receiving oxygen, dialysis and IV (intravenous) medications.

The comprehensive care plan for R8 failed to evidence a nursing care plan related to the Dobutamine IV medication.

The physician orders for R8 documented in part,
- "DOBUTamine HCl Solution Use 6.2 ml/hr (milliliter per hour) intravenously every 40 hours as needed for Change cassette and batteries PRN related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.20) ****RN ONLY**** Complete Cardiac Assessment Progress Note when changing (Baseline weight: 82.05 kg (kilogram) Dose: 2.5 mcg/kg/min (microgram per kilogram per minute)). Order Date: 12/13/2022."

On 5/10/2023 at 12:35 p.m., an interview was conducted with ASM (administrative staff

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member) #4, the assistant director of nursing. ASM #4 stated that the purpose of the care plan was to get an overall picture of the patient's care and should tell a story of why the resident was there. ASM #4 stated that they implemented the baseline care plan on admission and added things to it as they triggered.

On 5/26/2023 at 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan was to know the guideline of the resident's care and why they were in the facility. LPN #3 stated that the care plan started with the director of nursing and the managers. LPN #3 stated that the director of nursing, the managers and the nurses all reviewed and revised the care plans. LPN #3 stated that they would expect to see residents have care plans regarding cardiac drips to show the care they were to receive and monitoring.

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

3. For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan for treatment to wounds to the penis and a pressure ulcer on the left lateral foot.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/13/2023, the resident scored 15 out of 15 on the BIMS (brief interview for

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mental status), indicating the resident was cognitively intact for making daily decisions. Section M documented R6 having two Stage 3 pressure ulcers.

On 5/8/2023 at 3:00 p.m., an interview was conducted with R6 in their room. R6 stated that they had an area on their foot and another area from the urinary catheter. R6 stated that sometimes the nurses put a dressing on their foot and sometimes they did not and they wound doctor looked at the other area and they saw the urologist. A urinary catheter bag was observed attached to the bed frame on the right side of the bed. The bag was observed to be empty with clear yellow urine in the tubing. R6 stated that they were not sure what had happened but thought the catheter tubing had rubbed the area to cause the injury. R6 stated that the wound doctor came in almost every day and took care of their foot and the other area.

The comprehensive care plan for R6 documented in part, "CARE NEEDS: [Name of R6] has the following nursing care needs: osteoarthritis to left & right knee, COPD (chronic obstructive pulmonary disease), obesity, HTN (hypertension), GERD (gastroesophageal reflux disease), obstructive sleep apnea, insomnia, bladder neck obstruction, Depression, Anxiety, reflux, BPH (benign prostatic hypertrophy), depression/anxiety, constipation, neurocognitive d/o (disorder), mood disorder w/ assaultive behavior, vitamin D deficiency, elevated D-Dimer, heart failure, wounds. Created on: 06/23/2021, Revision on: 03/20/2023." Under "Interventions" it documented in part, "Administer medications and treatments as ordered..."

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The Wound Assessment Report from the wound nurse practitioner dated 5/1/2023 documented in part, "Wound Evaluation Date: 05/01/2023; Location: Left lateral foot; Measurements: Length: 1.60 cm (centimeter), Width: 1.00 cm, L x W: 1.60 cm(squared), Depth: 0.10 cm...Stage/Severity: Stage 3...Wound Status: Stable; 100% epithelial...Dressing change frequently: TID (three times a day), Clean wound with: Cleanse with soap and water, pat dry; Primary Treatment: Skin prep, Other dressings: Leave open to air..." The wound assessment report further documented, ""Wound Evaluation Date: 05/01/2023; Location: Penis; Measurements: Length: 1.50 cm (centimeter), Width: 0.60 cm, L x W: 0.90 cm(squared), Depth: 0.20 cm...Etiology: Trauma; Stage/Severity: Full Thickness...Wound Status: Stable; 100% granulation...Dressing change frequently: BID (twice a day), Clean wound with: Cleanse with wound cleanser; Primary Treatment: Calcium alginate, Bacitracin ointment, Other dressings: Leave open to air..."

The progress notes documented in part, "Skin/Wound Note 5/4/2023 12:22 Resident seen by wound care NP (nurse practitioner) 5/3/23 for wound assessment. Residents wound to L (left) foot is healed. Wound to penis remains present with 0 signs of worsening noted. Resident refuses ADL (activities of daily living) care often per staff. Resident educated on importance of peri care to promote healing. Resident verbalized understanding. Recommendations: Cleanse penis with NS (normal saline) or wound cleanser. Apply calcium alginate. L foot: apply skin prep TID. MD (medical doctor) made aware. Wound care will continue to monitor and treat."

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The physician orders for R6 documented in part, "Cleanse left foot with wound cleanser and apply medihoney and border gauze dressing daily and as needed every day shift. Order Date: 03/28/2023. Start Date: 03/29/2023." The physician orders failed to evidence the treatment orders from the 5/1/2023 nurse practitioners wound assessment. The physician orders further documented, "Cleanse penis with wound cleanser and apply xeroform twice daily and as needed as needed. Order Date: 03/28/2023. Start Date: 03/28/2023." The physician orders failed to evidence the treatment orders from the 5/1/2023 nurse practitioners wound assessment.

The eTAR (electronic treatment record) dated 5/1/2023-5/31/2023 for R6 documented in part, "Cleanse left foot with wound cleanser and apply medihoney and border gauze dressing daily and as needed every day shift. -Order Date- 03/28/2023 1939 (7:39 p.m.)." The eTAR documented the treatment completed on 5/1/23-5/4/23, 5/6/23 and 5/7/23. The documentation area for 5/5/23 was observed to be blank. The eTAR further documented, "Cleanse penis with wound cleanser and apply xeroform twice daily and as needed every day and evening shift -Order Date- 03/28/2023 1933 (7:33 p.m.)." The eTAR documented the treatment completed on 5/1/23-5/4/23, 5/6/23, once on 5/6/23 and on 5/7/23. The documentation area for 5/5/23 day shift was observed to be blank. The eTAR failed to evidence treatment the left foot pressure ulcer and the wound to the penis according to the wound nurse practitioners 5/1/2023 assessment.

On 5/9/2023 at 12:50 p.m., an interview was conducted with LPN (licensed practical nurse) #4,

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wound care nurse. LPN #4 stated that the wound nurse practitioner came in weekly and saw most of the residents in the building who had wounds. LPN #4 stated that they rounded with the nurse practitioner when they came in. LPN #4 stated that the nurse practitioner assessed the wounds, measured them and made changes to treatments as needed. LPN #4 stated that when changes were recommended from the nurse practitioner they notified the physician or the nurse practitioner in house that day to approve the changes the same day and entered the new orders. LPN #4 stated that the physician and the nurse practitioners went with the wound nurse practitioners recommendations because they were an expert. LPN #4 stated that R6 often refused wound care and it depended on the mood they were in. LPN #4 reviewed the wound nurse practitioner note dated 5/1/2023 and the wound progress note dated 5/4/2023 and stated that sometimes they got busy and they may not have put the orders in.

On 5/10/2023 at 12:35 p.m., an interview was conducted with ASM (administrative staff member) #4, the assistant director of nursing. ASM #4 stated that the purpose of the care plan was to get an overall picture of the patient's care and should tell a story of why the resident was there. ASM #4 stated that they implemented the baseline care plan on admission and added things to it as they triggered. ASM #4 stated that the care plan was not being implemented if the treatments were not being followed per the doctors orders.

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical

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services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

4. For Resident #9 (R9), the facility staff failed to develop a comprehensive patient centered care plan for the PICC (peripherally inserted central catheter) line (1) intravenous access.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/20/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section O documented R9 receiving IV (intravenous) medications.

On 5/10/2023 at 8:45 a.m., an interview was conducted with R9 in their room. R9 was observed in bed with a PICC line in place to the right upper arm and an infusion by portable pump at the bedside. When asked about care of the PICC line, R9 stated that the nurses had changed the dressing before but was not sure of how often they had done it.

The comprehensive care plan for R9 documented in part, "PICC: [Name of R9] has a PICC Line venous access. Created on: 03/14/2023. Revision on: 03/22/2023." Under "Interventions" it documented, "Notify MD (medical doctor) as indicated. Created on: 03/14/2023." The care plan failed to evidence any interventions regarding care of the PICC line.

On 5/10/2023 at 2:26 p.m., an interview was

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conducted with LPN (licensed practical nurse) #3. LPN #3 stated that PICC line dressings were changed weekly and assessed every shift. LPN #3 stated the purpose of the care plan was to know the guideline of the resident's care and why they were in the facility. LPN #3 stated that the care plan started with the director of nursing and the managers. LPN #3 stated that the director of nursing, the managers and the nurses all updated the care plans as needed. LPN #3 stated that a resident with a PICC line should have a care plan that addressed why they had the PICC line, how often they needed to flush the PICC line, dressing changes and care of the PICC line.

On 5/10/2023 at 12:09 p.m., an interview was conducted with ASM (administrative staff member) #4, assistant director of nursing. ASM #4 stated that the purpose of the care plan was to get an overall picture of the patient's care and should tell a story of why the resident was there. ASM #4 stated that they implemented the baseline care plan on admission and added things to it as they triggered. ASM #4 stated that a resident with a PICC line would have the site, the flushes, dressing change schedule and monitoring the site documented in their care plan.

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) A peripherally inserted central catheter (PICC

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line) is a type of central line. A central line (also called a central venous catheter) is like an intravenous (IV) line. But it is much longer than a regular IV and goes all the way up to a vein near the heart or just inside the heart. The other end of the PICC line stays outside of the body, usually where the arm bends. It may divide into more than one line. The end of each line is covered with a cap. This information was obtained from the website: https://kidshealth.org/en/parents/picc-lines.html

5. The facility staff failed to implement the comprehensive care plan for ADL (activities of daily living) care for Resident #1.

Resident #1 was admitted to the facility on 3/20/23 with diagnoses that included but were not limited to: CHF (congestive heart failure), diabetes mellitus, acute respiratory failure, and pulmonary edema.

The most recent MDS (minimum data set) assessment, a five-day Medicare assessment, with an ARD (assessment reference date) of 3/25/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, locomotion, walking, dressing, bathing and hygiene; supervision for eating.

A review of the comprehensive care plan dated 3/20/23 revealed, "FOCUS: The resident has a risk for pain related to bilateral leg wounds. The resident requires assistance with their activities of daily living due to chronic health conditions and

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recent hospitalization. The resident is incontinent of bladder and continent of bowels due to weakness INTERVENTIONS: Administer medications as ordered. Administer pain interview as indicated. Notify MD as indicated. Observe for physical indicators of pain. 2 persons assist transfer. Skilled OT/PT (occupational therapy/physical therapy). 1 person assist with toileting."

A review of the March 2023 TAR (treatment administration record) revealed incontinence care documentation missing in 1 of 11 day shifts (3/27), 1 of 12 evening shifts (3/30) and 5 of 12 night shifts (3/20, 3/22, 3/25, 3/28 and 3/31).

A review of the March 2023 TAR revealed dressing documentation missing in 1 of 11-day shifts (3/27) and 1 of 12 evening shifts (3/30).

A review of the March 2023 TAR revealed personal hygiene documentation missing in 1 of 11 day shifts (3/27) and 1 of 12 evening shifts (3/30).

A review of the April 2023 TAR revealed incontinence care documentation missing in 1 of 3 day shifts (4/1).

A review of the April 2023 TAR revealed dressing documentation missing in 1 of 3 day shifts (4/1).

A review of the April 2023 TAR revealed personal hygiene documentation missing in 1 of 3-day shifts (4/1) and 1 of 3 evening shifts.

An interview was conducted on 5/9/23 at 1:30 PM with LPN #6. When asked the purpose of the care plan, LPN #6 stated, the purpose of the care

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plan is to include the goals and interventions that the resident needs for care and to improve their functioning. When asked if there are holes in documentation, is the care plan being followed, LPN #6 stated no, it is not being followed.

An interview was conducted on 5/9/23 at 1:50 PM with CNA (certified nursing assistant) #3. When asked if the care plan for ADL's is being followed, if there are holes in the ADL documentation, CNA #3 stated, no, if it was not documented, it was not done, so the care plan is not being followed.

On 5/10/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the assistant director of nursing and ASM #8, the regional director of operations was made aware of the findings.

No further information was provided prior to exit.

6. The facility staff failed to implement the comprehensive care plan for a wander guard for Resident #2.

Resident #2 was admitted to the facility on 3/22/23 with diagnoses that included but were not limited to: dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/10/23, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility,

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transfers, walking, and locomotion. Section P-Restraints and Alarms P.0200 E. coded the resident as "wander / elopement alarm-not used".

A review of the comprehensive care plan dated 3/22/23, which revealed, "FOCUS: The resident is at risk for elopement related to confusion and disorientation, exit seeking. INTERVENTIONS: Check placement and function every shift. Elopement risk assessment as needed. Replace elopement band as needed. Wander guard to left ankle."

On 5/8/23 at 10:30 AM, Resident #2 was observed with wander guard to left ankle.

A review of physician orders, dated 3/22/23, revealed the following, "Check Wander Prevention Band every shift. Check Wander Prevention System Function Every Week-every Sunday.

A review of Resident #2's April 2023 TAR (treatment administration record) revealed: "Check Wander Prevention System Function Every Week every night shifts every Sun for Wandering/exit seeking." On 1 of 5 Sunday's missing documentation (4/9/23).

A review of Resident #2's April TAR revealed: "Check Wander Prevention Band every shift." There was missing documentation for day shift: 1 of 30 days (4/8/23), 3 of 30 evening shift (4/17, 4/26 and 4/27) and 2 of 30 night shift in April (4/8 and 4/9).

An interview was conducted on 5/9/23 at 1:30 PM with LPN #6. When asked the purpose of the care plan, LPN #6 stated, the purpose of the care

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plan is to include the goals and interventions that the resident needs for care and to improve their functioning. When asked if there are holes [blanks] in documentation, is the care plan being followed, LPN #6 stated no, it is not being followed.

On 5/10/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the assistant director of nursing and ASM #8, the regional director of operations was made aware of the findings.

No further information was provided prior to exit.

7. The facility staff failed to implement the comprehensive care plan for ADL care for Resident #4.

Resident #4 was admitted to the facility on 1/17/23 with diagnoses that included but were not limited to: pericardial effusion, CHF, CKD (chronic kidney disease) and DM (diabetes mellitus).

The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 4/25/23, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, walking, dressing, bathing and hygiene; supervision for eating and locomotion.

A review of the comprehensive care plan dated 1/17/23, revealed, "FOCUS: The resident

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requires assistance with
their activities of daily living due to chronic health conditions, recent hospitalization, weakness and CHF.
INTERVENTIONS: Provide peri-care with incontinent episodes. Provide toileting hygiene as needed for incontinent episodes. 1 person assist with bed mobility."

A review of the April 2023 TAR (treatment administration record) revealed incontinence care documentation missing for 3 of 20 day shifts (4/1, 4/22 and 4/23), 3 of 21 evening shifts (4/4, 4/7 and 4/27) and 3 of 21 night shifts (4/5, 4/7 and 4/19).

A review of the April 2023 TAR revealed dressing documentation missing on 3 of 20-day shifts (4/1, 4/22 and 4/23) and 3 of 21 evening shifts (4/4, 4/7 and 4/27).

A review of the April 2023 TAR revealed personal hygiene documentation missing on 3 of 20 day shifts (4/1, 4/22 and 4/23) and 3 of 21 evening shifts (4/4, 4/7 and 4/27).

A review of the May 2023 TAR revealed incontinence care documentation missing on 2 of 9 day shifts (5/6 and 5/8), 5 of 9 evening shifts (5/1, 5/3, 5/6, 5/7 and 5/8) and 2 of 9-night shifts (5/6 and 5/7).

A review of the May 2023 TAR revealed dressing documentation missing on 2 of 9 day shifts (5/6 and 5/8) and 5 of 9 evening shifts (5/1, 5/3, 5/6, 5/7 and 5/8).

A review of the May 2023 TAR revealed personal hygiene documentation missing on 2 of 9 day

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F 656	Continued From page 27 shifts (5/6 and 5/8) and 5 of 9 evening shifts (5/1, 5/3, 5/6, 5/7 and 5/8). An interview was conducted on 5/9/23 at 1:30 PM with LPN #6. When asked the purpose of the care plan, LPN #6 stated, the purpose of the care plan is to include the goals and interventions that the resident needs for care and to improve their functioning. When asked if there are holes [blanks] in documentation, is the care plan being followed, LPN #6 stated no, it is not being followed. An interview was conducted on 5/9/23 at 1:50 PM with CNA (certified nursing assistant) #3. When asked if the care plan for ADL's is being followed, if there are holes in the ADL documentation, CNA #3 stated, no, if it was not documented, it was not done, so the care plan is not being followed. On 5/10/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the assistant director of nursing and ASM #8, the regional director of operations was made aware of the findings. No further information was provided prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		5/31/23

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F 657	Continued From page 28 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review it was determined that the facility staff failed to review and/or revise the care plan for one of ten residents in the survey sample, Resident #8. The findings include: For Resident #8 (R8), the facility staff failed to review and/or revise the care plan after a fall on 1/20/2023. The progress notes for R8 documented in part, - "1/20/2023 5:37 a.m. fall evaluation...Unwitnessed fall. She was trying to go to the bathroom unassisted; she lost her balance and fell, hit her head on her whe [sic] she	F 657	F657 Care Plan Timing and Revision 1. Resident # 8 no longer resides in the facility. 2. Current residents have the potential to be affected. 3. The Regional Director of MDS or designee will educate MDS staff and nursing management (DON, ADON, Unit Managers and Supervisors) on the process for reviewing, updating care plans to reflect the current interventions for the resident after a fall and/or change in condition and followed. The Staff Development Coordinator or designee will educate all licensed nurses on the process for care plans with initiating ,reviewing, revising/ updating care plans	

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F 657	Continued From page 29 fell to the floor. She now has a large tennis-ball-size hematoma on the top of her scalp. Now with a new 7/10 (pain level 7 out of possible 10) headache. No skin tears or acute pain. Not on anticoagulation. On exam, no other overt physical signs of trauma. No reports of syncope, chest pain, or altered mental status. Neuro (neurological) checks are being performed per protocol. Vital signs are unremarkable. -she is requesting to go the ER (emergency room), which I agree is reasonable given the hematoma and new-onset headache....Patient is at risk for falls due to the following Loss of balance The patient's condition is worsening...Orders : transferred to the ER to rule out acute intracranial pathology..." - "1/20/2023 14:15 (2:15 p.m.) Resident returned form [sic] her ER visit with NNO (no new orders), pleasant & happy to be back. Arrived via stretcher & 3 person assist back to bed." The comprehensive care plan for R8 documented in part, "(Name of R8) is at risk for falls, due to generalized weakness. Created on: 12/14/2022." The care plan failed to evidence a review or revision after the fall on 1/20/2023. On 5/10/2023 at 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that when a resident had a fall and assessment was completed to check for injuries and treated as needed. LPN #3 stated that the responsible party and the physician were notified of the fall. LPN #3 stated that the purpose of the care plan was to know the guideline of the resident's care and why they were in the facility. LPN #3 stated that the director of nursing, the managers and the nurses all updated the care plans. LPN #3 stated that the residents care plan	F 657	to reflect the current interventions for the resident after a fall and/or change in condition and followed. 4. The MDS staff or designee will audit weekly x4 then monthly x 2 months the clinical records for falls and/or change in clinical condition to verify 10 residents care plan were reviewed, revised, and updated. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of Compliance 5/31/2023.	

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F 657	Continued From page 30 would be reviewed and revised as needed after a fall. The facility policy "Care Planning" dated 11/01/19 documented in part, "...Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment..." On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings. No further information was provided prior to exit.	F 657		
F 658 SS=E	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 resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to follow professional standards of care for three of ten residents in the survey sample, Residents #3, #8, and #6. The findings include: 1. For Resident #3 (R3), the facility staff failed to	F 658	F 658 Services Provided Meet Professional Standards 1. Resident #3 no longer resides in the facility. Resident #8 no longer resides in the facility. Resident #6 treatment order transcribed per physician order on 5/8/203. 2. Current residents in the center have the potential to be affected. The DON or	5/31/23

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administer medications in a timely manner.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section J documented R3 having pain frequently.

The physician orders for R3 documented in part,
- "Baclofen (1) Tablet 10 MG (milligram) Give 3 tablet by mouth four times a day for Muscle Spasms. May cause drowsiness, avoid alcohol. Order Date: 03/28/2022."
- "Gabapentin (2) Tablet 600 MG Give 1 tablet by mouth three times a day for Pain. Order Date: 03/28/2022."
- "tizanidine HCl (3) Tablet 4 MG Give 1 tablet by mouth three times a day for muscle spasms. Order Date: 04/13/2022."

The comprehensive care plan for R3 documented in part, "PAIN: [Name of R3] has potential for Pain related to disease process, impaired mobility. Created on: 03/30/2022, Revision on: 03/30/2022." Under "Interventions" it documented in part, "...Administered [sic] pain medication per physician orders Created on: 03/30/2022."

Review of the eMAR (electronic medication administration record) dated 7/1/2022-7/31/2022 documented the Baclofen 10 mg scheduled daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. The Gabapentin 600 mg was scheduled daily at 9:00 a.m., 1:00 p.m., and 5:00 p.m. The tizanidine HCL 4 mg was scheduled daily at 6:00

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designee conducted audit to verify residents with inotropic therapy had physician order for monitoring the administration rate, an audit on current resident that have recommendations by the wound NP has physician notification with transcription of new orders if applicable and an audit on current residents to identify medications not administered or not administered timely with physician notification of findings.
3. The SDC or designee will educate all the licensed nursed on the process and procedures for medication administration, physician notification with documentation medications not administered or not administered timely within the 2-hour timeframe, documentation of monitoring the administration rate for residents receiving inotropic therapy and transcribing wound NP recommendations per physician orders on same day of recommendation.
4. The Unit Manager or designee will complete weekly audits x 4 weeks the monthly x 2 to verify medications were administered and within the 2-hour timeframe, resident with inotropic therapy have physician orders for monitoring of administration rate and wound NP recommendations were transcribed per physician orders on same day of recommendation.
Results of the review will be presented to the QAPI committee for review and recommendation.
Once the committee determines the problem to no longer exist, the review will be conducted on a

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F 658	Continued From page 32 a.m., 2:00 p.m., and 10:00 p.m. Review of the Medication admin (administration) Audit report dated 7/1/2022-7/31/2022 documented the Baclofen 10 mg scheduled at 9:00 p.m. administered late on 7/3/2022 at 11:45 p.m., on 7/5/2022 at 11:06 p.m., on 7/7/2022 at 10:53 p.m., on 7/8/2022 at 11:59 p.m., on 7/10/2022 at 1:15 a.m., on 7/12/2022 at 11:19 p.m., on 7/13/2022 at 10:32 p.m., on 7/14/2022 at 12:02 a.m., and on 7/16/2022 at 10:41 p.m. The Baclofen 10 mg scheduled at 5:00 p.m. was administered late on 7/16/2022 at 8:14 p.m. The Gabapentin 600 mg scheduled at 9:00 a.m. was administered late on 7/16/2022 at 1:27 p.m. The Gabapentin 600 mg scheduled at 1:00 p.m. was administered late on 7/10/2022 at 2:37 p.m. and on 7/17/2022 at 2:44 p.m. The Gabapentin 600 mg scheduled at 5:00 p.m. was administered late on 7/3/2022 at 6:34 p.m., on 7/5/2022 at 6:29 p.m., on 7/17/2022 at 6:29 p.m., on 7/18/2022 at 7:36 p.m., on 7/27/2022 at 10:14 p.m., and on 7/29/2022 at 6:25 p.m. The Tizanidine 4 mg scheduled at 6:00 a.m. was administered late on 7/4/2022 at 7:30 a.m., on 7/10/2022 at 7:53 a.m., on 7/19/2022 at 7:34 a.m., on 7/20/2022 at 7:19 a.m., and on 7/24/2022 at 7:52 a.m. The Tizanidine 4 mg scheduled at 2:00 p.m. was administered late on 7/16/2022 at 5:36 p.m. The Tizanidine 4 mg scheduled at 10:00 p.m. was administered late on 7/3/2022 at 11:46 p.m., 7/8/2022 at 11:59 p.m., 7/9/2022 at 1:15 a.m. (7/10/2022), on 7/13/2022 at 11:46 p.m., on 7/14/2022 at 12:02 a.m. (7/15/2022), on 7/19/2022 at 12:55 a.m. (7/20/2022), on 7/20/2022 at 12:44 a.m. (7/21/2022), on 7/21/2022 at 12:45 a.m. (7/22/2022), on 7/22/2022 at 12:51 a.m. (7/23/2022), on 7/23/2022 at 1:02 a.m.	F 658	random basis. 5. Date of compliance 5/31/2023.	

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(7/24/2022), on 7/24/2022 at 11:21 p.m., on 7/28/2022 at 11:34 p.m., and on 7/29/2022 at 11:40 p.m.

The progress notes for R3 failed to evidence documentation regarding the late administration of the medications documented above.

On 5/8/2023 at 11:33 a.m., an interview was conducted with OSM (other staff member) #2, LTC (long term care) ombudsman. OSM #2 stated that they had worked with R3 at the facility and they had attempted to resolve concerns regarding late medications, in particular the pain medications. OSM #2 stated that R3 did not consistently receive their medications for pain and muscle spasms which delayed therapy appointments and decreased their ability to participate fully. OSM #2 stated that this was particularly an issue the month of July 2022 when the resident was on a particular unit.

On 5/10/2023 at 12:35 p.m., an interview was conducted with ASM (administrative staff member) #4, the assistant director of nursing. ASM #4 stated that the resident council had brought up concerns about timeliness of medications in the December meeting and they had wanted to know the timeframe before and after the scheduled time to get their medications. ASM #4 stated that they had discussed with the residents that the practice of an hour before and an hour after the scheduled time was within the range. When asked if any audits were performed on medication administration timeliness, ASM #4 stated that they would check.

On 5/10/2023 at 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #3.

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LPN #3 stated that medications were administered an hour before to an hour after the scheduled time. LPN #3 stated that they were administered in this window to keep the resident on a schedule and because of how the medications work. LPN #3 stated that when the medications were administered late the nurse should notify the physician and document it in the progress notes.

The facility policy "Medication Management/Medication Unavailability" dated 4/21/2022 failed to evidence guidance on administration of medication in a timely manner.

According to Fundamentals of Nursing 6th Edition, 2005: Patricia A. Potter and Anne Griffin Perry; Mosby, Inc., page 843, "All routinely ordered medications should be given within 60 minutes of the times ordered."

On 5/10/2023 at 4:25 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) Baclofen is used to treat pain and certain types of spasticity (muscle stiffness and tightness) from multiple sclerosis, spinal cord injuries, or other spinal cord diseases. Baclofen is in a class of medications called skeletal muscle relaxants. Baclofen acts on the spinal cord nerves and decreases the number and severity of muscle spasms caused by multiple sclerosis or

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spinal cord conditions. It also relieves pain and improves muscle movement. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html

(2) Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). Gabapentin extended-release tablets (Horizant) are used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Gabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal excitement in the brain. Gabapentin relieves the pain of PHN by changing the way the body senses pain. It is not known exactly how gabapentin works to treat restless legs syndrome. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html

(3) Tizanidine is used to relieve the spasms and increased muscle tone caused by multiple sclerosis (MS, a disease in which the nerves do not function properly and patients may experience weakness, numbness, loss of muscle coordination and problems with vision, speech, and bladder control), stroke, or brain or spinal injury. Tizanidine is in a class of medications called skeletal muscle relaxants. It works by slowing action in the brain and nervous system to

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allow the muscles to relax. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601121.html

2. For Resident #8 (R8), the facility staff failed to evidence monitoring of the administration rate of intravenous Dobutamine (1).

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/19/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section O documented R8 receiving oxygen, dialysis and IV (intravenous) medications.

The physician orders for R8 documented in part,
- "Cardiac Monitoring Q (every) Shift- vital signs, I &O (intake and output) & apos;s [sic] (I= intake, O= output), Labs reviewed (Y= labs reviewed, N= labs not reviews), mental status (A= alert, C= confused), Chest pain (Y= yes, N= No), Peripheral Pulse (Y= yes present, N= no pulses), Edema (Y= Yes, N= No), Catheter assessment (CDI= catheter site clean, dry and intact with no s/sx of infection, O= issue noted- follow up with provider) every shift for Monitoring. Order Date: 12/13/2022."
- "Monitor pump and cassette every shift every shift for Monitoring Note Y if functioning appropriately, note N if not functioning properly and follow up with provider. Order Date: 12/13/2022."
- "RN (registered nurse) ONLY to change cassette and batteries PRN. Complete Cardiac Assessment UDA (assessment) when changing

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F 658	Continued From page 37 as needed for Monitoring. Order Date: 12/13/2022." - "DOBUTamine HCl Solution Use 6.2 ml/hr (milliliter per hour) intravenously every 40 hours as needed for Change cassette and batteries PRN related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.20) ****RN ONLY**** Complete Cardiac Assessment Progress Note when changing (Baseline weight: 82.05 kg (kilogram) Dose: 2.5 mcg/kg/min (microgram per kilogram per minute)). Order Date: 12/13/2022." - "DOBUTamine HCl Solution Use 6.6 ml/hr intravenously every 40 hours as needed for Change cassette and batteries PRN related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.20) ****RN ONLY**** Complete Cardiac Assessment Progress Note when changing (Baseline weight:82.05 kg Dose: 2.5 mcg/kg/min). Order Date: 12/21/2022." - "DOBUTamine HCl Solution Use 6.4 ml/hr intravenously every 40 hours as needed for Change cassette and batteries PRN related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.20) ****RN ONLY**** Complete Cardiac Assessment Progress Note when changing (Baseline weight:82.05 kg Dose: 2.5 mcg/kg/min). Order Date: 12/30/2022." Review of the eMAR (electronic medication administration record) for R8 dated 12/1/2022-12/31/2022 documented the orders above. The eMAR failed to evidence cardiac monitoring on the day shift on 12/15/2022, 12/17/2022 and 12/31/2022, on the evening shift on 12/23/2022 and the night shift on 12/14/2022, 12/16/2022, 12/17/2022, 12/18/2022, 12/20/2022, and 12/21/2022. The eMAR failed to evidence any cassette and battery changes completed for	F 658		

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Dobutamine 6.2 ml/hr dosage ordered between 12/13/2022 and 12/21/2022. The eMAR failed to evidence staff monitoring the rate of the Dobutamine infusing via the pump each shift between 12/13/2022-12/31/2022.

Review of the eMAR for R8 dated 1/1/2023-1/31/2023 documented the orders above. The eMAR failed to evidence cardiac monitoring on the day shift on 1/1/2023, 1/14/2023, and 1/30/2023 and the night shift on 1/17/2023, 1/18/2023 and 1/31/2023. The eMAR failed to evidence staff monitoring the rate of the Dobutamine infusing via the pump each shift between 1/1/2023-1/31/2023.

Review of the eMAR for R8 dated 2/1/2023-2/28/2023 documented the orders above. The eMAR failed to evidence staff monitoring the rate of the Dobutamine infusing via the pump each shift between 2/1/2023-2/28/2023.

The progress notes for R8 failed to evidence a nursing assessment on 12/17/2022, 12/18/2022, 12/31/2022, and 1/14/2023.

The comprehensive care plan for R8 failed to evidence a nursing care plan related to the Dobutamine IV medication.

On 5/10/2023 at 9:30 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the RN's were called to come when the Dobutamine cassette and tubing needed to be changed. RN #1 stated that when the RN changed the cassette and the tubing they wrote a progress note and did a cardiac assessment. RN #1 stated that the assigned nurse each day completed an assessment each shift and wrote a

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skilled note and monitored the medication by checking the amount of medication in the cassette at the beginning and end of their shift. RN #1 stated that the assigned nurse each day should complete the cardiac monitoring on the eMAR, document that the medication was infusing on the eMAR, enter the vital signs and write a skilled note every shift. RN #1 stated that the RN's documented the cassette and battery change as needed on the eMAR. RN #1 reviewed R8's eMAR and stated that there should be a place where the staff were documenting the medication infusing at the prescribed rate every shift. RN #1 stated that R8 may have been their first resident and there was some trial and error.

On 5/10/2023 at 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the RN's changed the cardiac drip cassettes and pumps. LPN #3 stated that they monitored residents receiving the cardiac drips during their care by monitoring the pumps to ensure the medication was infusing at the prescribed rate and observed the amount of medication in the pump at the beginning and end of their shift. LPN #3 stated that they documented on the eMAR that the correct rate was infusing, that the pump was functioning and cardiac monitoring. LPN #3 stated that they also completed a skilled note in the computer every 12 hours for residents on cardiac drips.

The facility policy, "Administration of Inotropic Therapy" revised 3/14/2022 documented in part, "The following should be recorded in the resident's medical record: 1. The date and time the medication was administered. 2. The type of medication administered. 3. The amount of medication administered. 4. The route of

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administration. 5. The rate of administration..."

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) Dobutamine stimulates heart muscle and improves blood flow by helping the heart pump better. Dobutamine is used short-term to treat cardiac decompensation due to weakened heart muscle. Dobutamine is usually given after other heart medicines have been tried without success. This information was obtained from the website: https://www.drugs.com/mtm/dobutamine.html

3. For Resident #6 (R6), the facility staff failed to transcribe recommendations made by the wound nurse practitioner on 5/1/2023 for treatment to a wound on the resident's penis.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/13/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section H documented R6 having an indwelling catheter.

On 5/8/2023 at 3:00 p.m., an interview was conducted with R6 in their room. R6 stated that they had a urinary catheter. R6 stated that the wound doctor came in to see an area that the

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catheter had caused and they also saw a urologist about the area. R6 stated that they were not sure what had happened but thought the catheter tubing had rubbed the area to cause the injury.

On 5/9/2023 at approximately 9:05 a.m., an attempt was made to observe staff providing treatment to the wound to the penis however R6 refused the care.

The Wound Assessment Report from the wound nurse practitioner dated 5/1/2023 documented in part, "Wound Evaluation Date: 05/01/2023; Location: Penis; Measurements: Length: 1.50 cm (centimeter), Width: 0.60 cm, L x W: 0.90 cm(squared), Depth: 0.20 cm...Etiology: Trauma; Stage/Severity: Full Thickness...Wound Status: Stable; 100% granulation...Dressing change frequently: BID (twice a day), Clean wound with: Cleanse with wound cleanser; Primary Treatment: Calcium alginate, Bacitracin ointment, Other dressings: Leave open to air..."

The progress notes documented in part, "Skin/Wound Note 5/4/2023 12:22 Resident seen by wound care NP (nurse practitioner) 5/3/23 for wound assessment. Residents wound to L (left) foot is healed. Wound to penis remains present with 0 signs of worsening noted. Resident refuses ADL (activities of daily living) care often per staff. Resident educated on importance of peri care to promote healing. Resident verbalized understanding. Recommendations: Cleanse penis with NS (normal saline) or wound cleanser. Apply calcium alginate. L foot: apply skin prep TID. MD (medical doctor) made aware. Wound care will continue to monitor and treat."

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The physician orders for R6 documented in part, "Cleanse penis with wound cleanser and apply xeroform twice daily and as needed as needed. Order Date: 03/28/2023. Start Date: 03/28/2023." The physician orders failed to evidence the treatment orders from the 5/1/2023 nurse practitioners wound assessment.

The eTAR (electronic treatment record) dated 5/1/2023-5/31/2023 for R6 documented in part, "Cleanse penis with wound cleanser and apply xeroform twice daily and as needed every day and evening shift -Order Date- 03/28/2023 1933 (7:33 p.m.)." The eTAR documented the treatment completed on 5/1/23-5/4/23, 5/6/23, once on 5/6/23 and on 5/7/23. The documentation area for 5/5/23 day shift was observed to be blank. The eTAR failed to evidence treatment according to the wound nurse practitioners 5/1/2023 assessment.

The comprehensive care plan for R6 documented in part, "Immunological: [Name of R6] has infection of the Balanitis and recent cellulitis to lower extremities. Created on: 11/23/2022, Revision on: 03/20/2023." The care plan further documented, "FOLEY CATHETER: [Name of R6] requires urinary catheter related to: obstructive uropathy/bladder neck obstruction. Created on: 12/02/2022 Revision on: 12/02/2022." The care plan further documented, "BEHAVIORS: [Name of R6] has the potential to display the following behaviors; itching, picking at skin, refusals of care, aggression, restlessness, throwing food trays, emptying urine from catheter bag on the floor. Refusing meds and care at times. Created on: 05/18/2022 Revision on: 12/02/2022."

On 5/9/2023 at 12:50 p.m., an interview was

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F 658	Continued From page 43 conducted with LPN (licensed practical nurse) #4, wound care nurse. LPN #4 stated that the wound nurse practitioner came in weekly and saw most of the residents in the building who had wounds. LPN #4 stated that they rounded with the nurse practitioner when they came in. LPN #4 stated that the nurse practitioner assessed the wounds, measured them and made changes to treatments as needed. LPN #4 stated that when changes were recommended from the nurse practitioner they notified the physician or the nurse practitioner in house that day to approve the changes the same day and entered the new orders. LPN #4 stated that the physician and the nurse practitioners went with the wound nurse practitioners recommendations because they were an expert. LPN #4 stated that R6 often refused wound care and it depended on the mood they were in. LPN #4 reviewed the wound nurse practitioner note dated 5/1/2023 and the wound progress note dated 5/4/2023 and stated that sometimes they get busy and they may not have put the order in. The facility policy "Pressure Ulcer Monitoring & Documentation" dated 11/01/2019 failed to evidence guidance on following the current treatment orders for wounds. On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings. No further information was provided prior to exit.	F 658		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities	F 676		5/31/23

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CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)

§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.

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F 676	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of providing ADLs (activities of daily living) for two of 10 residents, Resident #1 and Resident #4. The findings include: 1. The facility staff failed to provide evidence of incontinence care, dressing and personal hygiene care for Resident #1. Resident #1 was admitted to the facility on 3/20/23 with diagnosis that included but were not limited to: CHF (congestive heart failure), diabetes mellitus, acute respiratory failure, pulmonary edema and hypertension (HTN). The most recent MDS (minimum data set) assessment, a five-day Medicare assessment, with an ARD (assessment reference date) of 3/25/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, locomotion, walking, dressing, bathing and hygiene; supervision for eating. A review of the comprehensive care plan dated 3/20/23, which revealed, "FOCUS: The resident has a risk for pain related to bilateral leg wounds. The resident requires assistance with their activities of daily living due to chronic health conditions and recent hospitalization. The resident is incontinent of bladder and continent of	F 676	F676 Activities of Daily Living (ADLs) /Maintain Abilities 1. Resident # 1 no longer resides in the facility. Resident # 4 timeframe has passed to correct. Resident #4 current ADL is complete. 2. Current residents in the facility have the potential to be affected. 3. The SDC or designee will educate all CNAs on providing ADL care with documentation in the clinical record for validation and verification services and care were provided for incontinent care, dressing and personal hygiene. 4. The UM or designee assess 10 residents weekly x 4 weeks the monthly x 2 months to verify ADL provided and documentation fir incontinent care, dressing and personal hygiene is complete in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 5/31/2023.	

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F 676	Continued From page 46 bowels due to weakness INTERVENTIONS: Administer medications as ordered. Administer pain interview as indicated. Notify MD as indicated. Observe for physical indicators of pain. 2 persons assist transfer. Skilled OT/PT (occupational therapy/physical therapy). 1 person assist with toileting." A review of the March 2023 TAR (treatment administration record) revealed incontinence care documentation missing in 1 of 11 day shifts (3/27), 1 of 12 evening shifts (3/30) and 5 of 12 night shifts (3/20, 3/22, 3/25, 3/28 and 3/31). A review of the March 2023 TAR revealed dressing documentation missing in 1 of 11-day shifts (3/27) and 1 of 12 evening shifts (3/30). A review of the March 2023 TAR revealed personal hygiene documentation missing in 1 of 11 day shifts (3/27) and 1 of 12 evening shifts (3/30). A review of the April 2023 TAR revealed incontinence care documentation missing in 1 of 3 day shifts (4/1). A review of the April 2023 TAR revealed dressing documentation missing in 1 of 3 day shifts (4/1). A review of the April 2023 TAR revealed personal hygiene documentation missing in 1 of 3-day shifts (4/1) and 1 of 3 evening shifts. An interview was conducted on 5/8/23 at 9:20 AM with CNA (certified nursing assistant) #1. When asked to describe incontinence care process for the residents, CNA #1 stated, "We do incontinence care every two hours or more often.	F 676		

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I am assigned to this unit so I know which residents may need to be changed more frequently." When asked where all of this care is documented, CNA #1 stated, it is documented on the ADL-CNA form. The incontinence care is under section of bowel/bladder elimination, bathing is documented under bathing and grooming is part of personal hygiene. When asked what blank spots in the documentation indicates, CNA #1 stated, "If it is not documented then it is not considered to be done." When asked the response time for call bells, CNA #1 stated, they try to go immediately, it is usually within 5-7 minutes.

An interview was conducted on 5/9/23 at 1:15 PM with Resident #4. Resident #4 scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Resident #4 is coded as always incontinent of bowel and bladder. When asked how frequently incontinence care is provided, Resident #4 stated, that is the only thing that is not good here. It takes them awhile when you call and I am sometimes only changed 1-2 times a shift.

An interview was conducted on 5/9/23 at 1:50 PM with CNA #3. When asked to describe incontinence care process for the residents, CNA #3 stated, "We do incontinence care every two hours or more often. If they can use their call bell, they sometimes call us if it is in between the 2 hours. Personally, I start by washing them and brushing their teeth and hair. Washing them up. putting them in new clothes. There is a schedule of showers or they get a bed bath." When asked where all of this care is documented, CNA #3 stated, it is documented on the ADL form. The

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incontinence care is under section of bowel/bladder elimination, bathing is documented under bathing and grooming is part of personal hygiene. When asked what blank spots in the documentation indicates, CNA #3 stated, "If there are blanks then the care was not given. We are not to have blanks in our documentation. You can see where there are codes to document the specifics."

On 5/10/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the assistant director of nursing and ASM #8, the regional director of operations was made aware of the findings.

A review of the facility's "General Care" policy dated 11/1/19, revealed, "Nursing personnel will provide basic nursing care and services following accepted standards of practice guidelines recognized by state boards of nursing as informed by national nursing organizations and/or nurse aide curriculum."

No further information was provided prior to exit.

2. The facility staff failed to provide evidence of incontinence care, dressing and personal hygiene care for Resident #4.

Resident #4 was admitted to the facility on 1/17/232 with diagnoses that included but were not limited to: pericardial effusion, CHF, CKD (chronic kidney disease) and DM (diabetes mellitus).

The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment,

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with an ARD (assessment reference date) of 4/25/23, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, walking, dressing, bathing and hygiene; supervision for eating and locomotion.

A review of the comprehensive care plan dated 1/17/23, revealed, "FOCUS: The resident requires assistance with
their activities of daily living due to chronic health conditions, recent hospitalization, weakness and CHF.
INTERVENTIONS: Provide peri-care with incontinent episodes. Provide toileting hygiene as needed for incontinent episodes. 1 person assist with bed mobility."

A review of the April 2023 TAR (treatment administration record) revealed incontinence care documentation missing for 3 of 20 day shifts (4/1, 4/22 and 4/23), 3 of 21 evening shifts (4/4, 4/7 and 4/27) and 3 of 21 night shifts (4/5, 4/7 and 4/19).

A review of the April 2023 TAR revealed dressing documentation missing on 3 of 20-day shifts (4/1, 4/22 and 4/23) and 3 of 21 evening shifts (4/4, 4/7 and 4/27).

A review of the April 2023 TAR revealed personal hygiene documentation missing on 3 of 20 day shifts (4/1, 4/22 and 4/23) and 3 of 21 evening shifts (4/4, 4/7 and 4/27).

A review of the May 2023 TAR revealed

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incontinence care documentation missing on 2 of 9 day shifts (5/6 and 5/8), 5 of 9 evening shifts (5/1, 5/3, 5/6, 5/7 and 5/8) and 2 of 9-night shifts (5/6 and 5/7).

A review of the May 2023 TAR revealed dressing documentation missing on 2 of 9 day shifts (5/6 and 5/8) and 5 of 9 evening shifts (5/1, 5/3, 5/6, 5/7 and 5/8).

A review of the May 2023 TAR revealed personal hygiene documentation missing on 2 of 9 day shifts (5/6 and 5/8) and 5 of 9 evening shifts (5/1, 5/3, 5/6, 5/7 and 5/8).

An interview was conducted on 5/8/23 at 9:20 AM with CNA (certified nursing assistant) #1. When asked to describe incontinence care process for the residents, CNA #1 stated, "We do incontinence care every two hours or more often. I am assigned to this unit so I know which residents may need to be changed more frequently." When asked where all of this care is documented, CNA #1 stated, it is documented on the ADL-CNA form. The incontinence care is under section of bowel/bladder elimination, bathing is documented under bathing and grooming is part of personal hygiene. When asked what blank spots in the documentation indicates, CNA #1 stated, "If it is not documented then it is not considered to be done." When asked the response time for call bells, CNA #1 stated, they try to go immediately, it is usually within 5-7 minutes.

An interview was conducted on 5/9/23 at 1:50 PM with CNA #3. When asked to describe incontinence care process for the residents, CNA #3 stated, "We do incontinence care every two

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hours or more often. If they can use their call bell, they sometimes call us if it is in between the 2 hours. Personally, I start by washing them and brushing their teeth and hair. Washing them up. putting them in new clothes. There is a schedule of showers or they get a bed bath." When asked where all of this care is documented, CNA #3 stated, it is documented on the ADL form. The incontinence care is under section of bowel/bladder elimination, bathing is documented under bathing and grooming is part of personal hygiene. When asked what blank spots in the documentation indicates, CNA #3 stated, "If there are blanks then the care was not given. We are not to have blanks in our documentation. You can see where there are codes to document the specifics."

On 5/10/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the assistant director of nursing and ASM #8, the regional director of operations was made aware of the findings.

A review of the facility's "General Care" policy dated 11/1/19, revealed, "Nursing personnel will provide basic nursing care and services following accepted standards of practice guidelines recognized by state boards of nursing as informed by national nursing organizations and/or nurse aide curriculum."

No further information was provided prior to exit.

F 677 SS=E ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) F 677 5/31/23

§483.24(a)(2) A resident who is unable to carry

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F 677	Continued From page 52 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents for two of ten residents in the survey sample, Residents #3 and #8. The findings include: 1. For Resident #3 (R3), the facility staff failed to provide incontinence care. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section G documented R3 being totally dependent on one staff member for personal hygiene and totally dependent on two or more persons for toileting. Section H documented R3 having an external catheter, receiving intermittent catheterization and being frequently incontinent of bowel. The comprehensive care plan for R3 documented in part, "INCONTINENCE: [Name of R3] has Bowel/Urinary incontinence related to impaired mobility, quadriplegia. Created on: 03/30/2022, Revision on: 03/30/2022." The care plan further documented, "ADLs: [Name of R3] has ADL Self care deficit related to physical limitations, quadriplegia. Created on: 03/30/2022, Revision	F 677	F677 ADL Care Provided for Dependent Residents 1. Resident #3 no longer resides in the facility. Resident #8 no longer resides in the facility. 2. Current residents in the facility have the potential to be affected. 3. The SDC or designee will educate all CNAs on providing incontinent care and/or toileting assistance for the resident and personal hygiene with documentation in the clinical record for validation and verification care and services were provided. 4. The UM or designee will assess 10 residents weekly x 4 weeks then monthly x 2 months to verify incontinent care and/or toileting assistance and personal hygiene was provided with documentation in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 5/31/2023.	

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on: 03/30/2022."

Review of the ADL documentation for R3 dated 7/1/2022-7/31/2022 under "Bowel Continence and Toilet Use" failed to evidence incontinence care provided on day shift on 7/1/2022, 7/3/2022, 7/6-7/8/2022, 7/19/2022, 7/23/2022, 7/27-7/28/2022, and 7/30-7/31/2022, on evening shift on 7/3/2022, 7/5/2022, 7/17-7/18/2022, 7/23/2022 and 7/27/2022, on night shift on 7/5/2022, 7/16/2022, 7/18/2022, 7/20/2022, 7/22-7/24/2022, and 7/25/2022.

On 5/8/2023 at 11:33 a.m., an interview was conducted with OSM (other staff member) #2, long term care ombudsman. OSM #2 stated that they worked with R3 at the facility regarding concerns of not receiving incontinence care timely from staff at the facility. OSM #2 stated that they had resolved some of R3's concerns with care but incontinence care remained an issue until they were discharged from the facility. OSM #2 stated that they visited R3 on 7/19/2022 and witnessed the staff entering the room but did not provide care for the resident. OSM #2 stated that R3 was a difficult resident and the staff appeared scared of them. OSM #2 stated that on 7/19/2022 they witnessed no one coming in the room for over two hours and the resident not getting changed until the next shift came in.

On 5/9/2023 at 1:06 p.m., an interview was conducted with LPN (licensed practical nurse) #5, wound care nurse. LPN #5 stated that they worked with R3 at the facility. LPN #5 stated that they did find R3 in feces at times and the resident would tell them that they had been laying like that for a while so they would clean them up. LPN #5 stated that R3 voiced frustration about having to

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go overnight without being cleaned up and that staff would leave them dirty.

On 5/9/2023 at 1:39 p.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that incontinence care was provided every two hours and as needed and documented in the computer every shift. CNA #3 stated that blank spaces under incontinence care meant that you did not do it and there were not supposed to be any blanks there.

The facility policy "Ancillary Nursing Care and Services" dated 11/01/19 documented in part, "Nursing personnel will provide basic nursing care and services following accepted standards of practice guidelines recognized by state boards of nursing as informed by national nursing organizations and as evidenced by hiring individuals who graduate from an approved nursing school and/or nurse aide curriculum and have successfully passed a licensing and/or certification examination..."

The facility provided reference from "Lippincott Chapter 22 pg. 324" documented in part, "...Incontinence is embarrassing. Garments get wet and odors develop. The person is uncomfortable. Skin irritation, infection and pressure ulcers are risks...Pride, dignity, and self-esteem are affected. Social isolation, loss of independence, and depression are common. Quality of life suffers..."

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were

F 677 Continued From page 55
made aware of the concern.

F 677

No further information was provided prior to exit.

2. For Resident #8 (R8), the facility staff failed to provide toileting assistance and/or incontinence care, and personal hygiene on numerous occasions from December 2022 through February 2023.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/19/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section G documented R8 requiring extensive assistance of one person for personal hygiene and toileting. Section H documented R8 being frequently incontinent of bowel and bladder.

Review of the ADL documentation for R8 dated 12/1/2022-12/31/2022 under "ADL-Toilet Use" and "Bowel/Bladder Elimination" failed to evidence toileting assistance and/or incontinence care provided on day shift on 12/14/2022, 12/17/2022, 12/25/2022, and 12/28/2022 on evening shift on 12/17/2022 and on night shift on 12/15/2022, 12/20-12/21/2022, 12/24-12/25/2022, and 12/28-12/29/2022. "ADL-Personal Hygiene" failed to evidence care provided on day shift on 12/14/2022, 12/25/2022 and 12/28/2022, and on evening shift on 12/17/2022. The areas were observed to be blank.

Review of the ADL documentation for R8 dated 1/1/2023-1/31/2023 under "ADL-Toilet Use" and "Bowel/Bladder Elimination" failed to evidence toileting assistance and/or incontinence care

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provided on day shift on 1/6/2023, 1/8-1/9/2023, 1/27/2023 and 1/30/2023, on evening shift 1/7/2023, 1/11/2023, 1/19/2023, 1/21/2023, 1/23/2023 and 1/28-1/29/2023 and on night shift 1/2-1/5/2023, 1/8-1/9/2023, 1/11-1/15/2023, 1/18-1/24/2023 and 1/28-1/29/2023.
"ADL-Personal Hygiene" failed to evidence care provided on day shift on 1/6/2023, 1/8-1/9/2023, 1/27/2023 and 1/30/2023 and on evening shift on 1/7/2023, 1/11/2023, 1/19/2023, 1/21/2023, 1/23/2023, and 1/28-1/29/2023. The areas were observed to be blank.

Review of the ADL documentation for R8 dated 2/1/2023-2/28/2023 under "ADL-Toilet Use" and "Bowel/Bladder Elimination" failed to evidence toileting assistance and/or incontinence care provided on day shift on 2/2/2023 and 2/5/2023, and on night shift 2/5/2023. "ADL-Personal Hygiene" failed to evidence care provided on day shift on 2/2/2023 and 2/5/2023. The areas were observed to be blank.

On 5/9/2023 at 1:39 p.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that incontinence care was provided every two hours and as needed and documented in the computer every shift. CNA #3 stated that blank spaces under incontinence care meant that you did not do it and there were not supposed to be any blanks there.

On 5/10/2023 at 10:52 a.m., an interview was conducted with CNA #6. CNA #6 stated that they worked with R8 in the facility. CNA #6 stated that R8 was alert and oriented and was able to use their call bell when they needed something. CNA #6 stated that R8 was able to perform some of their personal hygiene but they had to finish up

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F 677	Continued From page 57 what they could not do. CNA #6 stated that residents were bathed daily and received personal hygiene every shift. CNA #6 reviewed the ADL documentation for R8 and stated that it did not appear that they received a bath on 1/6/2023. On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the concern. No further information was provided prior to exit.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review it was determined that the facility staff failed to provide treatment to promote healing of a	F 686	F686 *Treatment/Svcs to Prevent/Heal Pressure Ulcers 1. Resident # 6 has treatment order per	5/31/23

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pressure ulcer/injury for one of ten residents in the survey sample, Resident #6.

The findings include:

For Resident #6 (R6), the facility staff failed to transcribe recommendations made by the wound nurse practitioner on 5/1/2023 for treatment to the pressure ulcer/injury (1) on the left lateral foot.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/13/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section M documented R6 having two Stage 3 pressure ulcers.

On 5/8/2023 at 3:00 p.m., an interview was conducted with R6 in their room. R6 stated that they had an area on their foot. R6 stated that sometimes the nurses put a dressing on their foot and sometimes they did not. R6 stated that the wound doctor came in almost every day and took care of their foot.

On 5/9/2023 at approximately 9:05 a.m., an attempt was made to observe staff providing care to the left foot pressure ulcer however R6 refused the care.

The Wound Assessment Report from the wound nurse practitioner dated 5/1/2023 documented in part, "Wound Evaluation Date: 05/01/2023; Location: Left lateral foot; Measurements: Length: 1.60 cm (centimeter), Width: 1.00 cm, L x W: 1.60 cm(squared), Depth: 0.10 cm...Stage/Severity: Stage 3...Wound Status:

F 686

physician order on 5/8/2023 and is being performed and documented. The physician was notified Resident #6 did not receive wound treatment on 5/5/2023.

2. Current residents in the facility have the potential to be affected. The DON or designee conducted an audit on residents with pressure wound treatment recommendations by the wound NP to verify were transcribed per physician order and performed per physician order.

3. The SDC will educate all licensed nurses on the process and procedure for performing wound care and documentation in the clinical record and physician notification of wound NP recommendations and transcribed in the clinical record per physician order.

4. The UM or designee will assess weekly x 4 weeks then monthly x 2 months to verify residents with pressure wound treatment recommendations by the wound NP were transcribed per physician order. Observation audits weekly x 4 weeks then monthly x 2 months on 5 residents with pressure wound care treatments to verify wound treatment performed and documented in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing is responsible for implementation of the plan of correction.

5. Date of compliance 5/31/2023.

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Stable; 100% epithelial...Dressing change frequently: TID (three times a day), Clean wound with: Cleanse with soap and water, pat dry; Primary Treatment: Skin prep, Other dressings: Leave open to air..."

The progress notes documented in part, "Skin/Wound Note 5/4/2023 12:22 Resident seen by wound care NP (nurse practitioner) 5/3/23 for wound assessment. Residents wound to L (left) foot is healed. Wound to penis remains present with 0 signs of worsening noted. Resident refuses ADL (activities of daily living) care often per staff. Resident educated on importance of peri care to promote healing. Resident verbalized understanding. Recommendations: Cleanse penis with NS (normal saline) or wound cleanser. Apply calcium alginate. L foot: apply skin prep TID. MD (medical doctor) made aware. Wound care will continue to monitor and treat."

The physician orders for R6 documented in part, "Cleanse left foot with wound cleanser and apply medihoney and border gauze dressing daily and as needed every day shift. Order Date: 03/28/2023. Start Date: 03/29/2023." The physician orders failed to evidence the treatment orders from the 5/1/2023 nurse practitioners wound assessment.

The eTAR (electronic treatment administration record) dated 5/1/2023-5/31/2023 for R6 documented in part, "Cleanse left foot with wound cleanser and apply medihoney and border gauze dressing daily and as needed every day shift. -Order Date- 03/28/2023 1939 (7:39 p.m.)." The eTAR documented the treatment completed on 5/1/23-5/4/23, 5/6/23 and 5/7/23. The documentation area for 5/5/23 was observed to

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be blank. The eTAR failed to evidence treatment according to the wound nurse practitioners 5/1/2023 assessment.

The comprehensive care plan for R6 documented in part, "(Name of R6) is alert and verbal. He has a significant change due to pressure ulcer... Created on: 06/14/2021. Revision on: 03/21/2023..."

On 5/9/2023 at 12:50 p.m., an interview was conducted with LPN (licensed practical nurse) #4, wound care nurse. LPN #4 stated that the wound nurse practitioner came in weekly and saw most of the residents in the building who had wounds. LPN #4 stated that they rounded with the nurse practitioner when they came in. LPN #4 stated that the nurse practitioner assessed the wounds, measured them and made changes to treatments as needed. LPN #4 stated that when changes were recommended from the nurse practitioner they notified the physician or the nurse practitioner in house that day to approve the changes the same day and entered the new orders. LPN #4 stated that the physician and the nurse practitioners went with the wound nurse practitioners recommendations because they were an expert. LPN #4 stated that R6 often refused wound care and it depended on the mood they were in. LPN #4 reviewed the wound nurse practitioner note dated 5/1/2023 and the wound progress note dated 5/4/2023 and stated that sometimes they get busy and they may not have put the order in.

On 5/9/2023 at 1:06 p.m., an interview was conducted with LPN #5, wound care nurse. LPN #5 stated that wound care was evidenced by documenting on the eTAR. LPN #5 stated that if

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the eTAR was blank they could not evidence that the care was provided.

The facility policy "Pressure Ulcer Monitoring & Documentation" dated 11/01/2019 failed to evidence guidance on following the current treatment orders for pressure ulcers.

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations.

No further information was provided prior to exit.

(1) Pressure Ulcer
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		5/31/23

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F 689	Continued From page 62 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to monitor a safety device for one of 10 residents in the survey sample, Residents #2. The findings include: Resident #2 did not have interventions implemented to monitor his wanderguard (a monitoring device that is worn by the resident that activates an alarm when a resident attempts to leave a safe/secured area) on six occasions in April 2023. Resident #2 was admitted to the facility on 3/22/23 with diagnosis that included but not limited to: dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/10/23, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as	F 689	F689 *Free of Accident Hazards/Supervision/Devices 1. Resident #2 current wanderguard is monitored with documentation. 2. Current residents in the facility have the potential to be affected. An audit conducted by the DON or designee on current residents with wanderguard have documentation for monitoring completed. 3. The SDC or designee will educate all licensed nurses on the process for residents with wanderguards are monitored, on and functional with verification of documentation completed in the clinical record. 4. The UM or designee will audit weekly x 4 weeks then monthly x 2 months to verify residents with wanderguards are monitored, on and functional with verification of documentation completed in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan	

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F 689	Continued From page 63 requiring limited assistance for bed mobility, transfers, walking, locomotion, dressing, hygiene and bathing; supervision for eating. Section P-Restraints and Alarms P.0200 E. coded the resident as "wander / elopement alarm-not used". A review of the comprehensive care plan dated 3/22/23 revealed, "FOCUS: The resident is at risk for elopement related to confusion and disorientation, exit seeking. INTERVENTIONS: Check placement and function every shift. Elopement risk assessment as needed. Replace elopement band as needed. Wander guard to left ankle." On 5/8/23 at 10:30 AM, Resident #2 was observed with a wanderguard worn on the left ankle. A review of physician orders, dated 3/22/23, revealed the following, "Check Wander Prevention Band every shift. Check Wander Prevention System Function Every Week-every Sunday. A review of the nursing note dated 3/22/23 at 12:30 PM, revealed, "Cognitive state on arrival: cognitively impaired. Oriented to person confused." A review of the nursing note dated 3/22/23 at 4:22 PM, revealed, "Resident eloped and was observed at a cafe next to facility after "Code Gray" was called and staff member brought [resident] back to facility. Wander guard was placed on residents left ankle. RP (responsible party) and NP (nurse practitioner) made aware of elopement and wander guard."	F 689	of correction. 5. Date of compliance 5/31/2023.	

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A review of the facility's "Elopement Risk Tool" dated 3/23/23, revealed, "Resident is at high risk for elopement. Eloped 3/22/23."

A review of Resident #2's April TAR: "Check Wander Prevention System Function Every Week every night shifts every Sun for Wandering/exit seeking." April 2023: 1 of 5 Sunday's missing (4/9/23).

A review of Resident #2's April 2023 TAR (treatment administration record): "Check Wander Prevention Band every shift" revealed missing documentation for day shift: 1 of 30 days (4/8/23), 3 of 30 evening shifts (4/17, 4/26 and 4/27) and 2 of 30 night shifts (4/8 and 4/9).

An interview was conducted on 5/9/23 at 1:30 PM, will LPN (licensed practical nurse) #6. When asked if there are holes [blanks] in the documentation, was there evidence that the wanderguard is being checked. LPN #6 stated, "No, if there are holes, we cannot validate that it was checked."

On 5/9/23 at approximately 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #4, the assistant director of nursing was made aware of the findings.

A review of the facilities "Missing Resident" policy dated 10/26/22, revealed, "In the event a patient is reported missing, a Code Orange will be activated and all available resources will be utilized to search for and find the patient as quickly as possible."

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F 689	Continued From page 65 No further information was provided prior to exit.	F 689		
F 694 SS=E	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide care and services to a peripherally inserted central catheter (PICC) intravenous line for two of ten residents in the survey sample, Residents #8 and #9. The findings include: 1. For Resident #8 (R8), the facility staff failed to evidence dressing changes were performed to a PICC line (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/19/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section O documented R8 receiving oxygen, dialysis and IV (intravenous) medications. The physician orders for R8 documented in part, - "Dressing: PICC/ Midline/ Tunneled	F 694	F694 Parenteral/IV fluids 1. Resident #8 no longer resides in the facility. Resident #9 the physician was notified on 5/15/2023 physician order revised to include day for PICC treatment for dressing changes and are currently being performed with documentation. 2. Current residents in the facility have the potential to be affected. An audit conducted by the DON or designee on current residents with PICC/ IV access site to verify has physician order with day to complete dressing changes, verify performed and has documentation completed in clinical record. 3. The SDC or designee will educate all licensed nurses on the process and procedure for PICC/IV site and performing dressing changes , documentation completed in the clinical record to verify treatment per physician order for PICC/IV site dressing change was performed. 4. The UM or designee will audit weekly x 4 weeks then monthly x 2 months to	5/31/23

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&Non-Tunneled weekly and PRN (as needed). Change needleless connector with weekly dressing change and after blood draw. If securement device is used, change at time of dressing change. as needed AND every day shift every Thu (Thursday) weekly. Order Date: 12/13/2022."

Review of the eTAR (electronic treatment administration record) for R8 dated 12/1/2022-12/31/2022 failed to evidence the PICC line dressing was changed on 12/29/2022 as ordered. Review of the eTAR for R8 dated 1/1/2023-1/31/2023 failed to evidence the PICC line dressing was changed on 1/5/2023 and 1/12/2023. The eTAR for R8 dated 2/1/2023-2/28/2023 failed to evidence the PICC line dressing was changed on 2/2/2023. The dates were observed to be blank.

The progress notes for R8 failed to evidence documentation that the PICC line dressing was changed on 12/29/2022, 1/5/2023, 1/12/2023 or 2/2/2023.

The comprehensive care plan for R8 documented in part, "(Name of R8) has a PICC line venous access. Created on: 12/14/2022." Under "Interventions" it documented in part, "...dressing change per order. Created on: 12/14/2022..."

On 5/9/2023 at 1:06 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that treatments were evidenced by signing them off on the eTAR. LPN #5 stated that if the eTAR was blank they could not evidence that the care was provided.

On 5/10/2023 at 2:26 p.m., an interview was

Provider's Plan of Correction (F 694, continued):

verify residents with PICC/IV site have physician orders with day to perform dressing change and documentation in the clinical record to verify treatment was performed. Observation audits of 5 residents with PICC/IV site to verify dressing changed per procedure was followed and documentation completed in clinical record weekly x 4 weeks then monthly x 2 months. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing is responsible for implementation of the plan of correction.

5. Date of compliance 5/31/2023.

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conducted with LPN (licensed practical nurse) #3. LPN #3 stated that PICC line dressings were changed weekly and assessed every shift. LPN #3 stated that PICC line dressing changes were documented in the progress notes and on the eTAR.

On 5/10/2023 at 4:02 p.m., an interview was conducted with LPN #9. LPN #9 stated that PICC line dressings were changed weekly. LPN #9 stated that the dressing changes came up on the computer to let them know when they were needed. LPN #9 stated that they could change the PICC line dressings but normally the RN changed the dressing when they were changing the medications for R9 and it would be documented in the progress notes.

The facility policy "Peripheral IV Site Management" dated 3/13/2023 failed to provide guidance on PICC line dressing care.

According to Lippincott Manual of Nursing Practice 10th edition, pg. 94 "Table 6-4 IV Catheter Maintenance Guidelines" it documented in part, "...Catheter: Peripherally inserted central catheter, Dressing change: 24 hours postinsertion, then weekly..."

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

Reference:

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(1) A peripherally inserted central catheter (PICC line) is a type of central line. A central line (also called a central venous catheter) is like an intravenous (IV) line. But it is much longer than a regular IV and goes all the way up to a vein near the heart or just inside the heart. The other end of the PICC line stays outside of the body, usually where the arm bends. It may divide into more than one line. The end of each line is covered with a cap. This information was obtained from the website:
https://kidshealth.org/en/parents/picc-lines.html

2. For Resident #9 (R9), the facility staff failed to evidence dressing changes to a PICC line.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/20/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section O documented R9 receiving IV (intravenous) medications.

On 5/10/2023 at 8:45 a.m., an interview was conducted with R9 in their room. R9 was observed in bed with a PICC line in place to the right upper arm and an infusion by portable pump at the bedside. When asked about care of the PICC line, R9 stated that the nurses had changed the dressing before but was not sure of how often they had done it.

The physician orders for R9 failed to evidence an order for PICC line dressing changes.

The comprehensive care plan for R9 documented in part, "PICC: (Name of R9) has a PICC Line

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venous access. Created on: 03/14/2023. Revision on: 03/22/2023." The care plan failed to evidence any interventions regarding care of the PICC line.

The eTAR (electronic treatment administration record) for R9 dated 3/1/2023-3/31/2023, 4/1/2023-4/30/2023 and 5/1/2023-5/31/2023 failed to evidence PICC line dressing changes.

The progress notes for R9 failed to evidence PICC line dressing changes.

On 5/10/2023 at 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that PICC line dressings were changed weekly and assessed every shift. LPN #3 stated that PICC line dressing changes were documented in the progress notes and on the eTAR.

On 5/10/2023 at 4:02 p.m., an interview was conducted with LPN #9. LPN #9 stated that PICC line dressings were changed weekly. LPN #9 stated that the dressing changes came up on the computer to let them know when they were needed. LPN #9 stated that they could change the PICC line dressings but normally the RN changed the dressing when they were changing the medications for R9 and it would be documented in the progress notes.

On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings.

No further information was provided prior to exit.

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F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to evidence training was completed for eight of 20 licensed nursing staff reviewed.	F 726	F726 Competent Nursing Staff 1. Facility staff identified # 13, #14 received in-service and the agency staff #10, #11,#12, #15, #16 will receive	5/31/23

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The findings include:

The facility staff failed to evidence training for monitoring residents receiving an intravenous cardiac drip medication in their care for eight licensed nursing staff, LPN (licensed practical nurse) #10, #11, #12, #13, #14, #15 and #16.

On 5/10/2023 at 8:40 a.m., a sample of 20 licensed nursing staff were chosen to review training on the monitoring and care of residents receiving continuous intravenous cardiac drip medications. The sample was chosen from the nursing staff documentation on an electronic medication administration record of a resident receiving Dobutamine solution (1) intravenously by a CADD (portable intravenous infusion) pump for congestive heart failure, in December of 2022. The list was provided to ASM (administrative staff member) #1, the administrator with the request for evidence of training provided to the selected staff.

On 5/10/2023 at approximately 10:00 a.m., RN (registered nurse) #2, staff development coordinator provided evidence of training completed on 3/29/2022 from the pharmacy with 14 nurses participating, training completed on 6/21/2022 with 20 nurses participating, on 12/15/2022 with 17 nurses participating and 1/9/2023 with 22 nurses participating. The sign-in sheets provided failed to evidence training for LPN #10, #11, #12, #13, #14, #15 or #16.

There were no adverse events identified due to the lack of documented training.

On 5/10/2023 at 11:17 a.m., an interview was conducted with RN #2. RN #2 stated that they

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training prior to assignment of residents with inotropic management.

6. Current residents in the facility have the potential to be affected. There are no other residents currently in the facility receiving inotropic management.
7. The SDC or designee will educate all licensed nurses on the process for physician orders, assessing, monitoring and required documentation for resident receiving inotropic management and completion of competency checklist.
8. The UM or designee will assess weekly x 4 weeks then monthly x 2 months to verify residents receiving inotropic management have assigned staff that have completed education and their competency checklist. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction.
9. Date of compliance 5/31/2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING ______ B. WING ______	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(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 726	Continued From page 72	F 726		

had been in their position since July of 2022 and had arranged a staff inservice in December on cardiac drips and the CADD pump. RN #2 stated that they had completed hands on training, how to load the cassette into the pump, how to read the monitor and had received examples of what the RN assessed and what the LPN assessed. RN #2 stated that the assigned nurse for the day documented their resident assessments every 12 hours on skilled notes, documented on the medication administration record that the that the medication was infusing and the pump was in place. RN #2 stated that the assigned nurse was monitoring vital signs, edema, any chest pain, the pulse, intake and output if it was ordered and assessing the IV site and documenting cardiac monitoring on the MAR. RN #2 stated that the RN's were trained to change the medication in the pump and the LPN's were trained to get the residual readings from the pump and monitor it daily. RN #2 stated that the LPN's would call the RN when the cartridge needed to be changed. RN #2 stated that the RN would do a cardiac assessment, write a progress note and document on the MAR in the as needed area when they changed the cartridge. At that time, RN #2 was made aware that LPN #10, #11, #12, #13, #14, #15 or #16 were not found on the training sign-in sheets provided. RN #2 reviewed the sign-in sheets and stated that they would look to see if they were able to find anything for them.

On 5/10/2023 at 2:06 p.m., RN #2 stated that they were not able to find any evidence of training for LPN #10, #11, #12, #13, #14, #15 or #16. RN #2 stated that LPN #10, #11, #12, #15 and #16 were agency staff and the only thing they were able to find were their general new hire papers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING ______ B. WING ______	C 05/10/2023

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WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 726	Continued From page 73 On 5/10/2023 at 1:05 p.m., an interview was conducted with OSM (other staff member) #7, staffing coordinator. When asked how they ensured that the nurses assigned to work with residents on cardiac drips had training to monitor the residents and the cardiac drips, OSM #7 stated that admissions and the director of nursing or the assistant director of nursing let them know when there were residents with cardiac drips so that they would schedule an RN around the clock for back up with the competencies. OSM #7 stated that they were working to get everyone CPR certified. The facility policy "Infusion Devices/Pumps" revised 02/2019 documented in part, "...Nurses shall be provided with verbal and/or written instructions regarding pump operation and care upon initial pump dispensing..." The facility policy "Administration of Inotropic Therapy" revised 3/14/2022 documented in part, "...The licensed nurse responsible for administering inotropic therapy shall be knowledgeable of: a. indications for use; b. appropriate doses and diluents; c. side effects; d. monitoring parameters; e. toxicities; f. incompatibilities; g. stability; h. storage requirements; and i. potential complications..." On 5/10/2023 at 4:25 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, assistant director of nursing and ASM #8, regional director of operations were made aware of the findings. No further information was provided prior to exit.	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING ______ B. WING ______	C 05/10/2023

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F 726	Continued From page 74 Reference: (1) Dobutamine stimulates heart muscle and improves blood flow by helping the heart pump better. Dobutamine is used short-term to treat cardiac decompensation due to weakened heart muscle. Dobutamine is usually given after other heart medicines have been tried without success. This information was obtained from the website: https://www.drugs.com/mtm/dobutamine.html	F 726		