STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/28/23 through 03/31/23 and 04/03/23. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Sixteen (16) complaints were investigated during the survey: VA00057934-Substantiated, without a deficiency, VA00057393-Substantiated, without deficiency, VA00057112 -Substantiated, without deficiency, VA00056600-Unsubstantiated, VA00055840-Unsubstantiated, VA00055250-Unsubstantiated, VA00054118-Substantiated, without deficiency, VA00052572-Substantiated, without deficiency, VA00052094-Substantiated, with deficiency, VA00052053-Substantiated, without deficiency, VA00051897-Unsubstantiated, VA00050342-Unsubstantiated, VA00050108-Unsubstantiated, VA00049903-Substantiated, without deficiency, VA00049540-Unsubstantiated, VA00058377-Unsubstantiated. The census in this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 62 Resident record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI)	F 641	The facility sets forth the following plan of correction to remain in compliance with all	5/15/23

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

Electronically Signed | 04/25/2023

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F 641	Continued From page 1 Manual, the facility failed to accurately assess the discharge for one of seven residents (Resident (R) 102) reviewed for discharge. This failure could lead to the inability to receive services outside the facility due to the payor source being informed R102 was still hospitalized. Findings include: Review of the October 2019 "RAI Manual," page A-32 showed: ". . .Item Rationale -Demographic and outcome information. Steps for Assessment 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Coding Instructions Select the 2-digit code that corresponds to the resident's discharge status. -Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home. . . ." Review of R102's "Admission Record" from the facility electronic medical record (EMR) "Profile" tab showed an admission date of 01/22/23, readmission 02/01/23. Review of R102's discharge return not anticipated "Minimum Data Set [MDS]" assessments with an assessment reference date (ARD) of 03/18/23 showed the discharge was coded as being discharged to an acute care hospital. Review of R102's discharge orders, dated 03/17/23, showed R102 was to be discharged on 03/18/23 to home.	F 641	federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following 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. F 641 Cross ref 12 VAC 5-371 -250 (A) resident assessment 1. Resident #102 no longer resides in the center. 2. Residents discharged from the center may be at risk related to inaccurate assessment of the discharge. Residents discharged from the center in the past 14 days will be reviewed by MDS nurses for accuracy related to discharge. 3. Regional Director of Reimbursement or designee will educate MDS nurses related to accurate assessment of resident discharge. 4. The MDS nurses will complete a weekly review of discharged patients to ensure accuracy of assessment upon discharge. Issues noted during the review will be presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. 5. Date of Completion: 5/15/2023	

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F 641	Continued From page 2 During an interview on 03/30/23 at 12:16 PM regarding the 03/18/23 MDS assessment, the MDS Coordinator (MDSC) stated, R102 "left on 3/18 and went home." MDSC reviewed the discharge orders, stated, "yes, home with home health." The MDSC reviewed the discharge MDS and exclaimed, "Oh no!" then confirmed the assessment was coded incorrectly. When asked if there was a policy regarding accuracy, MDSC stated, "We go by the RAI [Resident Assessment Instrument] manual or we ask the consultant." At 12:18 PM, the Regional MDS Consultant (RMDS) stated, "We follow the RAI [manual]."	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		5/15/23

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F 656	Continued From page 3 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 observation, clinical record review, staff interview and facility document, the facility staff failed to follow the comprehensive care plan intervention for on 03/02/23 for 1 of 62 residents (Resident #96) in the survey sample. The findings included: The facility staff failed to ensure fall mats were at bedside according to resident's comprehensive care plan as an intervention for a fall that occurred on 03/02/23 for Resident #96. The most recent Minimum Data Set (an	F 656	F656 Cross ref 12 VAC 5-371-250 (G) resident assessment 1. Resident # 96 no longer resides in the center. 2. Current residents have the potential to be affected related to not following the comprehensive care plan related to fall mats not being in place. 3. Staff development Coordinator or designee will educate Nurses on the requirement to verify interventions are in place per the resident□s comprehensive care plan. 4. The Unit manager or designee will	

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F 656	Continued From page 4 assessment protocol) an admission assessment with an Assessment Reference Date (ARD) of 03/06/23 coded the resident's Brief Interview for Mental Status (BIMS) score 14 of a possible 15 with no impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #96 requiring total dependence of one with bathing, extensive assistance of two with bed mobility and transfer, extensive assistance of one with dressing, toilet use and personal hygiene and supervision with one assistance with eating for Activities of Daily Living (ADL) care. In section "J" (Any falls since admission) the MDS was coded for having a fall after admission with major injury. Resident #96's care plan initiated on 03/01/23 identified the resident at risk for falls related to (r/t) cerebrovascular accident (CVA) affecting left side, muscle weakness, pain and left sided hemiparesis (weakness or inability to move on one side of the body.) The goal set for the resident by the staff is the resident will not have an injury related to a fall through the next review period 05/15/2023. One of the interventions/approaches the staff would use to accomplish this goal after a fall on 03/02/23 is to have fall mats at bedside. During the initial tour on 03/28/23 at 2:30 p.m., resident #96 observed lying in bed. Resident #96 stated since her recent stroke and keeps falling. She stated she fell some weeks ago, hitting her head causing it to bleed. An observation was made of the resident's room, no fall mats at beside or in the resident's room. On 03/30/23 at 9:42 a.m., resident #96 was observed sitting up in wheelchair in her room; floor mats were not observed in the resident's room. On the same	F 656	complete a random audit of resident care plans to ensure interventions are in place. Issues noted during the review will be presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. 5. Date of Completion: 5/15/2023	

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F 656	Continued From page 5	F 656		

day at approximately 5:28 p.m., resident observed lying in bed without floor mats at the bedside. On 03/31/23 at 2:26 p.m., resident observed lying in bed without fall mats at bedside.

A review of Resident #96's clinical record revealed the following fall:
-On 03/02/23, a fall nurse's note indicated Resident #96 attempted to ambulate without assistance resulting in an unwitnessed fall. The resident was found on the floor by the Certified Nursing Assistant (CNA.) The note stated the resident was looking for her phone and thought that it was in her suitcase. The resident was assessed and noted with a laceration over the left eyebrow, abrasion below the left eye and left shoulder.

On 03/31/23 at approximately 2:25 p.m., an interview was conducted with CNA #4. She stated Resident #96 has never had fall mats beside her bed. She stated she was not aware that she needed fall mats.

On 03/31/23 at approximately 2:40 p.m., License Practical Nurse (LPN) #9 went to Resident #96's room. Resident #96 was lying in bed without floor mats at the bedside. She looked around the resident's room and stated, "There are no fall mats anywhere."

An interview was conducted with MDS Nurse #1 on 03/31/23 at 4:03 p.m. She stated Resident #96 was care planned for floor mats after her fall on 03/02/23. She stated during their stand-up meeting every morning, all falls are discussed, and the resident's care planned are updated with the Unit Manager's present. She stated the UM's are responsible to ensure the fall interventions

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F 656	Continued From page 6 are followed through. On 04/03/23 at 1:58 p.m., the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services were informed of the above findings. No further information was provided prior to exit. The facility's policy titled Falls Management Program effective date 11/01/19. Policy: The Center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systems approach to a Falls Management Program that conducts multi-faceted, interdisciplinary assessments with evidence-based interventions to develop individual care strategies. Fall Occurrences (Immediate Responsibility) 1. (a) Incorporate identified interventions into the Comprehensive Care Plan as applicable. 4. A licensed nurse will review, revise, and implement interventions to the care plan based on: Post Fall Assessment findings, review of Devise Assessment and review of Fall Risk Assessment. Follow-Up Responsibilities: 1. The Unit Manager will review the Incident Report and any post fall follow-up and communicate any necessary fall management interventions to direct caregivers.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an	F 660		5/15/23

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effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's

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F 660	Continued From page 8 comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and review of facility policies, the facility failed to ensure for a safe discharge home for one of seven residents (Resident (R) 204) reviewed for discharge planning out of a total sample of 62 residents. This resulted in R204 being discharged home	F 660	F 660 Cross ref 12 VAC 5-371-140 (A) (D) Policies and procedures 1. Resident 204 no longer resides in the center. 2. Residents discharged from center without follow up related to needed	

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F 660	Continued From page 9 without necessary equipment, a walker and feeding tube supplies, subsequently the resident readmitted to the hospital. Findings include: Review of the facility's policy titled, "Discharge Planning Role in Skilled/Transitional Care" dated 01/06/20, and provided by the facility stated, "Discharge planning staff will proactively spearhead the discharge planning process and follow through to completion to ensure a discharge in which the patient returns to the community environment as safe, function, and independent as possible . . . finalize and confirm services prior to discharge . . . initiate Discharge Planning Instructions in [electronic medical record (EMR)] and verify completion . . ." Review of the facility's policy titled, "Discharge Instructions" dated 01/06/20, and provided by the facility stated, ". . . Discharge planning staff will complete the Discharge Planning section of the Discharge Instructions form to provide the patient and family/caregivers with information and written instructions in preparation for the patient's post discharge care. The Discharge Instructions meet the guidelines of providing a final written summary of services delivered, goals achieved, and post discharge plan of care at the time of the patient's discharge from the Center. All Discharge Instructions are to be signed by the patient or receiving/discharging party of the patient . . . At the time of discharge, the Discharge Instruction form must be reviewed with the patient and the patient and/or responsible party must sign. One copy will be sent with the patient when they are discharged. A second signed copy is to be scanned into the patient record. Once the patient	F 660	supplies including enteral feeding needs have the potential to be affected. Review of residents within the last 14 days who have required home supplies will be completed. 3. Administrator or designee will educate Discharge planning associates on the need to follow up on delivery of services to ensure a safe functional discharge and the need to review discharge plan with appropriate Responsible party and provide copy of discharge plan. 4. Discharge planner will complete review of all patients discharged with a need for home supplies to ensure they have been delivered and complete a weekly audit related to review and education re discharge plan to resident or responsible party. Issues noted during the review will be presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. 5. Date of completion: 5/15/2023	

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has been discharged from the Center, complete a detailed Discharge Planning Progress Note, summarizing the services arranged for the patient for discharge by service/item ordered, provider name, location of discharge, and method of transportation. Indicate any refusals of service, need, or recommendation procurement."

Review of R204's "Admission Record" located in the EMR under the "Resident" tab indicated the resident was readmitted to the facility on 05/01/21 with a primary diagnosis of stroke and comorbidities including hemiplegia, hemiparesis, protein calorie malnutrition, aphasia (unable to comprehend or formulate language due to stroke/head trauma), dysphagia (difficulty swallowing), metabolic encephalopathy, gastrostomy tube, and vascular dementia. The resident was discharged home on 05/29/21.

Review of R204's admission "Minimum Data Set (MDS)" with "Assessment Reference Date (ARD)" of 05/07/21 and located in the EMR under the "MDS" tab revealed a "Brief Interview of Mental Status (BIMS)" was unable to be completed due to severe cognitive impairment. Functional status for activities of daily living (ADL) indicated bed mobility of extensive assistance, and transfers, dressing, toileting, and personal hygiene required total assistance. Nutritional status indicated he had a feeding tube prior to admission to the facility and continued with tube feedings and nothing by mouth.

Review of R204's "Discharge Planning Progress Notes" located in the EMR under the "Progress Notes" tab dated 05/12/21 stated, "DPD [discharge planning director] spoke with patients son . . . on regards to discharge planning.

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Patients sone stated patient plan is to return home. Patients son stated that family preparing the home for patient to stay on the first level. Patients son also stated that family will be providing 24/7 care for patient. DPD asked if patients family would like for assistance at home, that discharge can assist with personal care, Medicaid. Patients son declined. Stated family will do rotation for 24/7. Discharge planning will continue to monitor and assist as needed."

Review of R204's "Discharge Planning Progress Notes" located in the EMR under the "Progress Notes" tab dated 05/20/21 stated, "Care plan meeting was held on 05/20/21 with IDT [interdisciplinary team] members in attendance, input from CNA [certified nursing assistants] was included in the review of the care plan. Res. [resident] was in attendance. Daughter and spouse were in attendance. Discharge plans are unsure. Patients daughter will speak to the family and update discharge planning. Current care plan goals and orders was given. POC [plan of care] will remain the same at this time."

Review of R204's "Discharge Summary" provided by the facility and dated 05/26/21 by the Nurse Practitioner (NP) 2 indicated that the resident was to be discharged home on 05/29/21 due to his insurance no longer covering his stay at the facility. The resident's family was to take him home and provide 24-hour care; wife is the emergency contact and has dementia, so family will need to be involved. R204 was noted to have not had any meaningful recovery since his admission. Labs were drawn on this date and pending results, recently noted with elevated renal/kidney function labs (BUN/creatinine ratio). The note stated R204 needed close follow-up by

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primary care physician (PCP) and all other outpatient specialists/providers upon discharge from facility. Medications were listed, medical history reviewed, and physical exam included patient not opening his eyes, was nonverbal, and did not follow any commands. Skin noted to be dry to lower extremities with " ...very long thick toenails noted on both feet ..." Discharge orders included discharge on 05/29/21 to " ...home with family; follow up with PCP within one week and for PCP to follow up on status post acute CVA [stroke], dysphagia [difficulty swallowing], HTN [hypertension], oral thrush, recent UTI [urinary tract infection], elevated BUN/creatinine ratio ...Home Health for PT/OT [physical/occupational], skilled nursing, medication management, HHA [home health aide], personal care aide, DME [durable medical equipment] needed: hospital bed, wheelchair, front wheeled walker, 3 in 1 commode; activity/restrictions: activity as tolerated; diet/restrictions: Jevity 1.2 at 60 ml [milliliters]/hour via PEG [percutaneous endoscopic gastrostomy- tube feeding] tube continuously; nothing by mouth; water flush 150ml via PEG tube every 6 hours routine . . . all written prescriptions to be given to patient upon discharge, home health nurse for feeding tube care/supplies/education, head of bed must be elevated 30-45 degrees at all times . . ."

Review of R204's "Discharge Planning Progress Notes" located in the EMR under the "Progress Notes" tab and dated 05/26/21 stated "Patient will discharge home on Saturday 05/29/21 at 11am, Home Health TBD [to be determined] but will provide PT/OT/SN Eval/HHA. Family medical supply will provide hospital bed, w/c, 3:1. Transportation will be provided via transport. Discharge due to insurance cut. Patient and

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family were made aware of discharge on 05/26/21. Discharge Planning will continue to monitor and assist as needed ...DPD set up transport for discharge with ... pick [sic] time:4PM."

Review of R204's "Discharge Instructions/Post Discharge Plan of Care - V 2" provided by the facility and dated 05/26/21 at 12:11 PM was not filled out or signed by the nursing department and did not indicate if patient education was provided, dietary department instructions included "NPO [nothing by mouth], provide Jevity 1.2 cal [calorie] @ 60 ml [milliliters] per hour continuous via PEG tube- May hold TF 1-2 hours per day for activities of daily living, personal care, etc. Provide water flushes of 150ml four times a day via PEG tube . . ." Physical, occupational, and speech therapy sections not filled out or signed, "discharge planning" section included resident to be discharged home, "Patient will discharge home on Saturday 05/29/21 at 11am. [Home Health Company] will provide PT/OT/SN Eval/HHA. Family medical supply will provide hospital bed, w/c, 3:1 [three in one bedside commode].Transportation will be provided via transport [sic] Discharge due to insurance cut. Patient and family were made aware of discharge on 05/26/21 . . ." Responsible party did not sign indicating they received the information.

Review of R204's "Discharge Orders" dated 05/26/21, provided by the facility, and signed by NP2 included discharge date of 05/29/21, home health orders to include physical, occupational, and speech therapy, along with home health aide and personal care assistant; medical equipment to include hospital bed, wheelchair, front wheeled walker, three in one commode; dietary restrictions

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for tube feeding and wound care to PEG tube site; specific instructions for home health nurse for feeding tube care/ supplies/education, head of the bed must be elevated 30-45 degrees at all times, home health nurse to check BMP (basic metabolic panel) on Tuesday, 06/01/21 and call results to primary care physician. Copy of paper medication orders were attached to the "Discharge Orders." No indication as to whether the patient's family/responsible party was educated or provided with this information.

During an interview on 03/30/23 at 9:35 AM, the DPD stated R204 was discharged to home on 05/29/21. DPD reviewed documentation to include the Home Health Company was to provide therapy and nursing services, and a home health aide. DPD stated she ordered a hospital bed, bedside commode, feeding tube equipment, and wheelchair. DPD stated that the resident's son was involved in the resident's care and that the Nurse Practitioner had written discharge instructions on 05/26/21 and provided to the facility. The DPD stated that she spoke with R204's son on 05/12/21 at which time he told her that the family would provide around the clock care for R204. When asked which nursing staff attended the care conference on 05/20/21, she did not have that information, nor could she confirm that the nursing department provided education to the resident's responsible party.

During an interview on 03/30/23 at 4:50 PM, the Billing Manager of the medical supply company confirmed that a hospital bed, bedside commode, and manual wheelchair were delivered on 05/28/21 and picked up on 02/14/22 for R204. The four-wheeled walker in discharge orders was not included in the delivery.

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During an interview on 03/31/23 at 9:36 AM, the Registered Nurse Manager of the home health agency stated that R204 was supposed to be admitted to home health (HH) services on 05/29/21, but was put on hold due R204 being sent back to the hospital due to no tube feeding or supplies in the home as of 05/29/21. R204 was then admitted to home health services on 06/01/21 at which time education was provided to the family on tube feedings and medication administration.

During an interview on 03/31/23 at 10:23 AM, DPD stated she could not locate the date the medical equipment and feeding supplies were ordered, she was aware of the tube feeding and home health nursing needs and that once the referral for discharge is provided by the physician, that information is sent over to the home health agency. DPD stated the facility protocol was for her to email the home health agency, a representative from the HH Agency then calls her to let her know that staff are scheduled to admit the resident on a specific date. The DPD did not have documentation of who she spoke with at the HH Agency, the date or time, or a confirmation call confirming HH Agency was planning on admitting the resident on 05/29/21. DPD provided name and phone number of the infusion company that would have been contacted to provide the feeding pump and supplies. All home health agencies and medical equipment supports are expected to call the DPD if there will be a delay in service. The DPD was unaware that R204 readmitted to the hospital on 05/29/21 due to a lack medical supports in place.

During an interview on 03/31/23 at 10:58 AM, the

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Administrator, Director of Nurses, and the Regional Director of Clinical Services confirmed R204 was readmitted to the facility on 05/01/21 and discharged to home on 05/29/21. The DON located a physician note indicating that the resident was hospitalized from 06/01/21-06/08/21. Staff indicated that the home health nurse typically sees the resident within 48 hours of arriving at home. The DON, Administrator, and Regional Director of Clinical Services were not able to provide confirmation that R204's responsible party was provided education for a safe discharge home, however, they felt that the DPD's instructions to the family were adequate. Additionally, staff could not locate documentation of the NP providing education to the responsible party either. The Administrator and DON were not aware of R204 not being admitted to home health services on 05/29/21 and that he did not have appropriate feeding pump and supplies in place for a safe discharge home.

During an interview on 03/31/23 at 11:00 AM, the infusion company's Director of Nurses stated R204 was to be discharged home on 05/29/21 and that the company delivered a feeding pump and supplies on 05/30/21; the pump was then picked up on 07/27/21.

During an interview on 03/31/23 at 11:16 AM, the MDS Coordinator and MDS Nurse indicated R204 was discharged from the facility on 05/29/21, they could not locate documentation of nursing staff providing education to the responsible party to ensure a safe discharge home, they were unable to locate documentation confirming that anyone from the nursing department attended the care conference meeting held on 05/20/21.

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F 660	Continued From page 17 Additionally, the MDS nurses stated that it was common practice for the facility to have two to three days to prepare for a resident's discharge and that based on discharge planning progress note, the home health agency should have been notified on 05/26/21. During an interview on 04/03/23 at 1:33PM with the Administrator via telephone, stated R204 was provided adequate discharge instructions per review of "Discharge Orders" and "Discharge Instructions." The Administrator was not aware that R204 did not receive feeding pump or supplies until 05/30/21 or that he was not admitted to home health nursing services until 06/01/23. The Administrator stated there was no way of the facility knowing that he did not receive supports in a timely manner and that they operate as if the home health visit was set up and that once the agency had accepted the resident there was no follow-up call placed. Additionally, once the home health agency is contacted, the medical equipment is requested and the family is notified of the discharge date and time. The Administrator was not able to provide documentation to prove that the family was educated on resident medical needs or that they received discharge instructions.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F 661		5/15/23

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F 661	Continued From page 18 radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all the resident's pre- and post-medications for one of seven residents (Resident (R) 204) reviewed for discharge in a total sample of 62 residents. Findings include: Review of the facility's policy titled, "Discharge Instructions" dated 01/06/20, and provided by the facility stated, ". . .Discharge planning staff will complete the Discharge Planning section of the	F 661	F 661 Cross ref VAC 12 5-371-360 (E) (11) Clinical records 1. Resident # 204 no longer resides in the center. 2. Residents discharged from the center have the potential to be affected. A 14-day lookback will be completed to review recapitulation summaries have been completed. 3. Administrator or designee will educate Physician staff including extenders on requirement to complete a recapitulation summary of resident stay including reconciliation of pre and post medications. 4. Discharge planner will complete a review of all patients discharging to	

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F 661	Continued From page 19 Discharge Instructions form to provide the patient and family/caregivers with information and written instructions in preparation for the patient's post discharge care. The Discharge Instructions meet the guidelines of providing a final written summary of services delivered, goals achieved, and post discharge plan of care at the time of the patient's discharge from the Center. All Discharge Instructions are to be signed by the patient or receiving/discharging party of the patient . . . At the time of discharge, the Discharge Instruction form must be reviewed with the patient and the patient and/or responsible party must sign. One copy will be sent with the patient when they are discharged. A second signed copy is to be scanned into the patient record. Once the patient has been discharged from the Center, complete a detailed Discharge Planning Progress Note, summarizing the services arranged for the patient for discharge by service/item ordered, provider name, location of discharge, and method of transportation. Indicate any refusals of service, need, or recommendation procurement." Review of R204's "Admission Record" located in the EMR under the "Resident" tab indicated the resident was readmitted to the facility on 05/01/21 with a primary diagnosis of stroke and comorbidities including hemiplegia, hemiparesis, protein calorie malnutrition, aphasia (unable to comprehend or formulate language due to stroke/head trauma), dysphagia (difficulty swallowing), metabolic encephalopathy, gastrostomy tube, and vascular dementia. The resident was discharged home on 05/29/21. Review of R204's admission "Minimum Data Set (MDS)" with "Assessment Reference Date (ARD)" of 05/07/21 revealed a "Brief Interview of	F 661	ensure a recapitulation summary of resident's stay has been completed to include pre and post medications. Issues noted during the review will be presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. 5. Date of completion: 5/15/2023	

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Mental Status (BIMS)" was unable to be completed due to severe cognitive impairment. Functional status for activities of daily living (ADL) indicated bed mobility of extensive assistance, and transfers, dressing, toileting, and personal hygiene required total assistance. Nutritional status indicated he had a feeding tube prior to admission to the facility and continued with tube feedings and nothing by mouth.

Review of R204's "Discharge Summary" provided by the facility and dated 05/26/21 by the Nurse Practitioner (NP) 2 indicated R204 was to be discharged home on 05/29/21 due to his insurance no longer covering his stay at the facility. R204's family was to take him home and provide 24-hour care; "wife is the emergency contact and has dementia, so family will need to be involved." R204 was noted to have not had any meaningful recovery since his admission. Labs were drawn on this date and pending results, recently noted with elevated renal and kidney function labs (BUN/creatinine ratio). The note indicated close follow-up by primary care physician (PCP) and all other outpatient specialists/providers upon discharge from facility. Medications were listed, medical history reviewed, and physical exam included patient not opening his eyes, was nonverbal, and did not follow any commands. Skin noted to be dry to lower extremities with "very long thick toenails noted on both feet . . ." Discharge orders included discharge on 05/29/21 to home with family; follow up with PCP within one week and for PCP to follow up on status post acute "CVA [stroke], dysphagia [difficulty swallowing], HTN [hypertension], oral thrush, recent UTI [urinary tract infection], elevated BUN/creatinine ratio . . . Home Health for PT/OT [physical/occupational],

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skilled nursing, medication management, HHA [home health aide], personal care aide, DME [durable medical equipment] needed: hospital bed, wheelchair, front wheeled walker, 3 in 1 commode; activity/restrictions: activity as tolerated; diet/restrictions: Jevity 1.2 at 60 ml [milliliters]/hour via PEG [percutaneous endoscopic gastrostomy- tube feeding] tube continuously; nothing by mouth; water flush 150ml via PEG tuve every 6 hours routine . . . all written prescriptions to be given to patient upon discharge, home health nurse for feeding tube care/supplies/education, head of bed must be elevated 30-45 degrees at all times. . . "

Review of R204's "Discharge Planning Progress Notes" located in the EMR under the "Progress Notes" tab and dated 05/26/21 stated "Patient will discharge home on Saturday 05/29/21 at 11am, Home Health TBD [to be determined] but will provide PT/OT/SN Eval/HHA. Family medical supply will provide hospital bed, w/c, 3:1. Transportation will be provided via transport. Discharge due to insurance cut. Patient and family were made aware of discharge on 05/26/21. Discharge Planning will continue to monitor and assist as needed ...DPD [discharge planning director] set up transport for discharge with ... pick [sic] time:4PM."

Review of R204's "Discharge Instructions/Post Discharge Plan of Care - V 2" provided by the facility and dated 05/26/21 at 12:11 PM was not filled out or signed by the nursing department and did not indicate if patient education was provided, dietary department instructions included "NPO [nothing by mouth], provide Jevity 1.2 cal [calorie] @ 60 ml per hour continuous via PEG tube- May hold TF 1-2 hours per day for activities of daily

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living, personal care, etc. Provide water flushes of 150ml four times a day via PEG tube . . ." Physical, occupational, and speech therapy sections not filled out or signed, "discharge planning" section included resident to be discharged home . . ."Patient will discharge home on Saturday 05/29/21 at 11am. [home health company] will provide PT/OT/SN Eval/HHA. Family medical supply will provide hospital bed, w/c, 3:1 [three in one bedside commode].Transportation will be provided via transport [sic] Discharge due to insurance cut. Patient and family were made aware of discharge on 05/26/21. . ." Responsible party did not sign indicating they received the information.

Review of R204's "Discharge Orders" dated 05/26/21, provided by the facility, and signed by Nurse Practitioner (NP) 2 included discharge date of 05/29/21, home health orders to include physical, occupational, and speech therapy, along with home health aide and personal care assistant; medical equipment to include hospital bed, wheelchair, front wheeled walker, three in one commode; dietary restrictions for tube feeding and wound care to PEG tube site; specific instructions for home health nurse for feeding tube care/ supplies/education, head of the bed must be elevated 30-45 degrees at all times, home health nurse to check basic metabolic panel (BMP) on Tuesday, 06/01/21 and call results to primary care physician. Copy of paper medication orders were attached to the "Discharge Orders." No indication as to whether the patient's family/responsible party was educated or provided with this information.

During an interview on 03/30/23 at 9:35 AM, the DPD stated R204 was discharged to home on

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F 661	Continued From page 23	F 661		

05/29/21. DPD reviewed documentation to include Home Health was to provide therapy and nursing services, and a home health aide. Additionally, she stated she ordered a hospital bed, bedside commode, feeding tube equipment, and wheelchair. DPD stated R204's son was involved in the resident's care and that the Nurse Practitioner had written discharge instructions on 05/26/21 and provided to the facility. Regarding the discharge summary, each department should fill out instructions, the medication orders are printed out, the initial referral is sent out to the home health agency, then the provider sends complete orders to the home health agency. DPD confirmed the nursing and therapy departments did not fill out their portions of the discharge summary instructions. When the DPD was asked for a recapitulation of stay, she asked what that was and stated she was not familiar with that.

During an interview on 03/31/23 at 10:58 AM, the Administrator, Director of Nursing, and the Regional Director of Clinical Services confirmed R204 was readmitted to the facility on 05/01/21 and discharged to home on 05/29/21. The DON located a physician note indicating that R204 was hospitalized from 06/01/21-06/08/21. The DON, Administrator, and Regional Director of Clinical Services were not able to provide confirmation that R204's responsible party was provided education for a safe discharge home, however, they felt that the DPD's instructions to the family were adequate. Additionally, staff could not locate documentation of the NP providing education to the responsible party either. The Administrator and DON were not aware of R204 not being admitted to home health services on 05/29/21 and that he did not have appropriate feeding pump and supplies in place for a safe discharge

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F 661	Continued From page 24 home. During an interview on 03/31/23 at 6:00 PM, the Director of Nursing and the Administrator, it was confirmed that the DPD had entered a "Discharge Summary and "Discharge Orders" in the EMR, however, the DON and Administrator were not familiar with the need for a recapitulation of stay and were not able to provide documentation of such report. During an interview on 04/03/23 at 1:33PM with the Administrator via telephone, stated R204 was provided adequate discharge instructions per review of "Discharge Orders" and "Discharge Instructions." The Administrator was not able to provide documentation to prove that the family was educated on resident medical needs, that they received discharge instructions or a recapitulation of stay.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to provide grooming assistance to one of three residents (Resident (R) 204) reviewed for Activities of Daily Living (ADL) care. This failure had the potential to affect the residents' comfort, body image, increase the risk for skin breakdown, and increase the risk for infections.	F 677	F 677 Cross ref 12 VAC 5-371 220 (D) Nursing services 1. Resident #204 no longer resides in the center. 2. Current residents have potential to be affected. 3. Staff development coordinator or designee will educate all licensed staff on need to provide grooming assistance to	5/15/23

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F 677	Continued From page 25 Findings include: Activities of Daily Living/Hygiene/Bathing Policy was requested on 03/31/23 and 04/03/23 and was not provided. A copy of the front of the book titled, "Mosby's Textbook for Long-Term Care Nursing Assistants" was provided by the Administrator. Review of R204's "Admission Record" located in the EMR under the "Resident" tab indicated the resident was readmitted to the facility on 05/01/21 with a primary diagnosis of stroke and comorbidities including hemiplegia, hemiparesis, protein calorie malnutrition, aphasia (unable to comprehend or formulate language due to stroke/head trauma), dysphagia (difficulty swallowing), metabolic encephalopathy, gastrostomy tube, and vascular dementia. Review of R204's admission "Minimum Data Set (MDS)" with "Assessment Reference Date (ARD)" of 05/07/21 revealed a "Brief Interview of Mental Status (BIMS)" was unable to be completed due to severe cognitive impairment. Functional status for activities of daily living (ADL) indicated bed mobility of extensive assistance, and transfers, dressing, toileting, and personal hygiene required total assistance. The resident was incontinent of bowel and bladder. The resident was discharged home on 05/29/21. Review of R204's "Care Plan" located in the EMR under the "Care Plan" tab created on 05/03/21 included the resident having ADL self-care performance deficits related to muscle weakness, difficulty walking, acute stroke with left sided weakness, and brain trauma as a child. Staff to provide sponge bath when a full bath or shower	F 677	residents daily and upon request. 4. Unit manager or designee will complete a random weekly review of grooming via activity of daily living documentation. Issues noted during the review will be presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. 5. Date of completion: 5/15/2023	

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cannot be tolerated ...required anticipation of needs, assistive device (wheelchair), safety ques, appropriate footwear, keep environment free of trip hazards... The care plan did not include bowel/bladder incontinence status.

Review of R204's "Documentation Survey Report" for May 2021 certified nurse's aide documentation revealed no documentation for bed mobility, dressing, hygiene, toileting, bowel/bladder elimination, and skin monitoring on 05/01/21-05/02/21, 05/09/21, 05/15/21, 05/19/21, 05/27/21-05/29/21 and no documentation for one-two shifts on the following dates: 05/03/21-05/05/21, 05/07/21-05/08/21, 05/10/21-05/14/21, 05/17/21-05/18/21, 05/20/21, 05/22/21-05/26/21.

Review of R204's "Documentation Survey Report" for May 2021 certified nurse's aide documentation revealed bathing was scheduled for Saturday/Wednesday. Documentation revealed the resident was only bathed on 05/05/21, 05/08/21, 05/26/21, and 05/29/21 (bathing not done on 05/12/21, 05/15/21, 05/19/21, and 05/22/21). The resident did not receive a bath/shower from 05/09/21-05/25/21 and no refusals were noted.

Review of R204's "Skilled Note" located in the EMR under the "Progress Notes" tab and dated 05/13/21 stated the resident was " ...total assist with ADLs ..."

Review of R204's "Discharge Summary" provided by the facility and dated 05/26/21 by the nurse practitioner indicated that the resident had " ...very long thick toenails noted on both feet ..."

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During an interview on 03/30/23 at 6:05 PM, Licensed Practical Nurse (LPN) 3 stated she was not familiar with R204 but that the facility policy was to provide ADL assistance every three hours and as needed. The staff providing care should document what support was provided and that if it was not documented it was not done.

During an interview on 03/30/23 at 6:15 PM, Certified Nursing Assistant (CNA) 2 stated rounds were to be done for all residents every two to three hours. CNA2 was not familiar with R204, but if staff had provided for showers or incontinent care it should have been documented in the EMR.

During an interview on 03/30/23 at 6:23 PM, CNA3 stated she was not familiar with R204, but CNAs should do rounds for all residents every 2-3 hours and document care provided in EMR.

During an interview on 03/31/23 at 6:00 PM with the Director of Nurses (DON) and Administrator confirmed that Certified Nursing Assistants were to provide rounds every two to three hours and were provided training from "Mosby's Textbook for Long-Term Care Nursing Assistants Eighth Edition." A copy was requested of specific training courses but was not provided. Documentation of "Documentation Survey Report" for May 2021 was provided by the Administrator.

During an interview on 04/03/23 at 10:43 AM with the Administrator via telephone, stated that the Certified Nursing Assistants (CNAs) were to look at the task listed in the EMR to determine what assistance a resident required, they should then document accordingly. If a resident refused care, the CNA should document as such. When asked

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F 677	Continued From page 28 what it meant if there was no documentation/ task was left blank she stated that the task was done on a different shift. When asked what it means if an entire day was left blank with no documentation, she stated she would have to look back at R204's documentation to see if the EMR was not working that day to see if paper documentation was available. No supporting documentation was able to be provided to confirm that ADL assistance was provided to R204 on the dates mentioned in "Documentation Survey Report" for May 2021. The Administrator was not aware of any complaints of ADL support not being provided to this resident.	F 677		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review, and review of facility documents, the facility staff failed to manage pain by adhering to the prescribed medication regimen for 2 of 3 residents (Resident #304 and 310) reviewed for pain mangement out of a total sample of 62 residents which constituted harm. The findings included: 1. The facility staff failed to obtain Resident #304's pain medication Oxycodone HCl 5 mg capsules from the Omnicell backup medication	F 697	F 697 Cross ref 12 VAC 5-371-220 (A) (B) nursing services 1. Resident # 304 no longer resides in center. Resident # 310 no longer resides in center. 2. Newly admitted residents have the potential to be at risk. Residents over past 14 days have been reviewed to ensure that pain medication was provided, and resident pain management was appropriate. 3. Staff Development coordinator or designee will educate nurses on use of	5/15/23

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F 697	Continued From page 29 system when it was requested and due, which resulted in the resident experiencing continuous severe pain for greater than 27 hours, which constituted harm. Resident #304 was originally admitted to the facility 3/22/23 after an acute care hospital stay and she had never been discharged from the facility. The current diagnoses included; a right total hip replacement secondary to osteoarthritis. The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed therefore the following information was obtained from the Admission/Readmission Nursing Collection Tool dated 03/23/2023. The tool revealed the resident was oriented to person and situation, required setup or clean-up assistance with eating and oral hygiene, and she was independent with sitting to lying, moving from sitting on side of bed to lying flat on the bed. No other activities were attempted due to safety concerns. The assessment also revealed the resident had experienced frequent moderate pain over the last 5 days. On 3/29/23 at 9:45 a.m., Resident #304 stated her pain level was a "9" using a pain scale of 0 to 10; with 0 equaling no pain and 10 equaling severe pain. The resident stated she could hardly complete her shower earlier that morning with the therapist because her leg hurt so badly, and she wasn't going to participate in therapy later that day if the pain wasn't better. Resident #304 stated she last received the prescribed pain medication Oxycodone HCl 5 mg two capsules at 2:45 a.m., that morning (3/29/23) and she had requested more Oxycodone HCl at 6:55 a.m., and it was now 9:45 a.m. and she still had not	F 697	Omnicell, use of house stock medications, request for stat deliveries of medications, requests for written prescriptions for controlled medications and notification to physician should medication not be available and request for alternate. 4. Unit manager or designee will complete a weekly review of newly admitted residents to ensure pain management has been acceptable to the resident. Issues noted during the review will be presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. 5. Date of Completion: 5/15/2023	

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received the pain medication.
The resident further stated her daughter provided the facility with a supply of 42 Oxycodone HCl 5 mg capsules on 3/23/23 and she had requested and received the pain medication as close to every four (4) hours as possible to stay ahead of the pain but now she was behind the pain and didn't think she would get ahead of the pain again. The resident stated she was aware the Oxycodone HCl had to be requested but lately when it was requested, she wasn't always administered the medication. The resident stated some of the nurse's told her they had to get a code prior to obtaining the medication since her personal supply was exhausted.
On 3/29/23 at 5:23 p.m., the resident stated although her pain level was at "9" she attended the afternoon therapy session, but she couldn't perform as she expected because she had been in severe pain all day. Resident #304 also stated when she requested the Oxycodone HCl 5 mg capsules the only pain medication they offered her was Acetaminophen Extra Strength 500 mg which upsets her stomach. Resident #304 stated because the nurses will not administer her the Oxycodone HCl 5 mg capsules so she can get and keep the pain under control she was going to telephone her daughter to come and take her home where she can get the pain medications, necessary to regain control of the right leg and hip pain.

On 3/30/23 at 9:50 a.m., Resident #304 stated she had been without the Oxycodone HCl 5 mg capsule since 9/29/23 at 9:45 a.m. and she could no longer tolerate the pain, receiving only Acetaminophen Extra Strength 500 mg which was not helping at all. She stated she had spoken with discharge planning, and she would

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be leaving as soon as the discharge could be coordinated.
On 3/30/23 at 10:30 a.m. the resident was administered Oxycodone HCl 5 mg capsule - 2 capsules which were obtained from the Omnicell (a backup automated medication system that requires a code and prior authorization). Based on the interview with Resident #304 she stated she had been in severe pain since 3/29/23 at 6:45 a.m., which was greater than (27) consecutive hours.

Resident #304's current physician order summary revealed the following as needed pain medication orders dated 3/23/23; Oxycodone HCl 5 milligram (mg) capsule - Give 1 capsule by mouth every 4 hours as needed for mild pain, Oxycodone HCl 5 mg capsule- Give 2 capsule by mouth every 4 hours as needed for severe pain, and Acetaminophen Extra Strength Oral Tablet 500 mg - Give 2 tablet by mouth every 6 hours as needed for mild pain.

The resident's current care had a problem dated 3/23/23 which read at risk for pain related to diabetes with neuropathy, a right hip replacement, and muscle weakness. The goal read the resident's pain will be resolved thru the review period of 6/21/23. The interventions included administering medications as ordered, administering a pain interview as indicated, observing for physical indicators of pain, pain assessment as needed, and notifying MD as indicated.

The resident arrived at the facility with a prescription for forty-two (42) Oxycodone HCl 5 mg capsules and documentation revealed the prescription was faxed to the pharmacy on

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3/23/23 at 12:54 a.m. Thirty (30) capsules were processed in the pharmacy to be delivered to the facility, yet as of 3/31/23, they had not arrived to be administered to the resident. An investigation was opened by the pharmacy on 3/30/23 regarding the missing thirty (30) Oxycodone HCl 5 mg capsules after the survey team inquired about the status of the medication. As a result of the missing (30) Oxycodone HCl 5 mg capsules, once the 42 capsules provided by the resident's daughter were exhausted on 3/28/23 at 2:29 a.m. there were only three capsules left to obtain from the Omnicell. Two of the three capsules were administered on 3/29/23 at 2:45 a.m. after it was obtained from the Omnicell at 1:01 a.m.

A document containing conversations between the pharmacy representative and the facility's nurse revealed the pharmacists representative informed the facility staff on 3/29/23 at 12:58 a.m. that there were only three (3) tablets left on the prescription they had on hand and after that withdrawal, there would be only one tablet left to be withdrawn from the Omnicell, and a new prescription would be needed before additional Oxycodone HCl 5 mg capsules could be sent out. On 3/29/23 at 2:10 p.m., (greater than 12 hours later) a new prescription for 30 capsules was sent to the pharmacy; 24 tablets were processed to be sent to the facility and 6 capsules were reserved for immediate use administration from the Omnicell. The 24 capsules arrived at the facility on 3/30/23 at 1:01 p.m.

On 3/30/23 at Pharmacist #1 confirmed that Oxycodone HCl 5 mg capsule and Oxycodone IR 5 mg tablet are compatible medications and one can be substituted for the other A pharmacy inventory of the medication Oxycodone HCl 5 mg

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capsule on 3/29/23 revealed RN #1 did not attempt to access Oxycodone IR 5 mg tablet from the Omnicell on 3/29/23 and the not stocked message was not for the medication Oxycodone IR 5 mg tablet and on 3/29/23 at 12:28 p.m. there were eight (8) Oxycodone IR 5 mg tablet available in the Omnicell. The inventory further revealed that twelve (12) tablets were added to the Omnicell at 7:06 p.m. and there was no activity for the medication between 1:00 p.m. and 11:00 p.m. and the Omnicell par level for Oxycodone IR 5 mg tablet remained 20 tablets until 3/30/23 at 10:23 a.m. when 2 tablets were obtained for Resident #304. The inventory report concluded that the Omnicell had not been without Oxycodone IR 5 mg tablet in the month of March 2023.

An interview was conducted with the Rehabilitation Director and Certified Occupational Therapy Assistant (COTA) #1 on 3/31/23 at 2:15 p.m. COTA #1 stated the resident had participated in her therapy session earlier that day and her performance was excellent in comparison to previous sessions, in which she complained of pain and not being able to complete the designated tasks. COTA #1 stated Resident #304 participation and performance on 3/30/23 was so outstanding that she wondered, "Who is this lady and where has she been all this time?"

An interview was conducted with Registered Nurse (RN) #1 on 3/31/23 at approximately 2:40 p.m. RN #1 stated on 3/29/23 at approximately 10:30 a.m. an attempt was made to obtain Oxycodone HCl 5 mg capsule - 2 capsules from the Omnicell after the resident requested the medication, but she received a message stating

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that the medication was out of stock.
On 4/3/23 at approximately 1:50 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided, and no further concerns were voiced.

2. The facility staff failed to provide pain management to Resident #310 based on his request which resulted in unnecessary severe pain at a level "10" multiple times, which constituted harm.

Resident #310 was originally admitted to the facility on 3/27/23 after an acute care hospital stay and he had never been discharged from the facility. The current diagnoses included left total knee replacement secondary to osteoarthritis. The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed therefore the following information was obtained from the Admission/Readmission Nursing Collection Tool dated 03/27/2023. The tool revealed the resident was oriented to person, place, time, and situation, is independent with eating, oral care,
requires partial/moderate assistance with toileting transfers, and to move from sitting to lying. No other activities were attempted due to safety concerns. The assessment also revealed the resident had experienced occasional moderate pain over the last 5 days.

An interview was conducted with Resident #310 on 3/30/23 at approximately 5:40 p.m. The resident stated he had experienced periods of severe pain at a level "10" since his admission to

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the facility using a pain scale of 0 to 10; with 0 equaling no pain and 10 equaling severe pain. The resident stated what bothered him the most was, some of the nurses were giving him a hard time when he requested his pain medication. The resident stated prior to his discharge from the hospital he was told his pain medication Oxycodone HCl 5 mg 1 or 2 could be requested every 3 to 4 hours. The resident stated he arrived to the facility around noon on 3/27/23 and his pain level reached "10" before he received his first dose of Oxycodone HCl 5 mg at 6:45 p.m. and at that time Licensed Practical Nurse (LPN) #5 told him his Oxycodone HCl 5 mg schedule was changed from every 4 hours to every 6 hours with no rationale for the change. The resident stated his next dose of Oxycodone HCl 5 mg two capsules were administered to him on 3/28/23 at 1:30 a.m. and again his pain level was "10". Resident #310 stated he went to the nurse's station on 3/28/23 at 5:00 a.m. to let LPN #7 know he was experiencing severe pain, at a level "10" and he was told by the nurse that his Oxycodone HCl 5 mg two capsules could not be administered until 5:30 a.m. and because of LPN #7's response the resident began to log in his note pad each request and each administration of his Oxycodone HCl 5 mg. The resident stated he didn't receive the 5:30 a.m. Oxycodone HCl 5 mg two capsules until 8:30 a.m. by LPN #8. The resident also stated LPN #8 informed him that he could request and receive the pain medication every 4 hours and if he is told he cannot have it every 4 hours to tell the nurse to look on page 3 to validate every 4 hours order.

Another interview was conducted with Resident #310 on 3/31/23 at approximately 10:40 a.m.

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Resident #310 stated for a couple of days administration of his pain medication was smoother and the pain was better until 3/31/23 at 1:30 a.m. he stated he told LPN #6 he had pain at a level "10" and she informed him that he only had Oxycodone HCl 5 mg two capsules left and if he took both at that time, he would not have any in 4 hours to take. The resident stated he told LPN #6 he wanted the two capsules, and she administered them to him. Resident #310 stated on 3/31/23 at 5:35 a.m. he again requested Oxycodone HCl 5 mg two capsules and LPN #6 ignored him, and at 6:05 a.m. LPN #6 stated she didn't have his Oxycodone HCl 5 mg, but she had sent a message to the pharmacy to have more delivered to the facility and he would be able to get it once it was delivered.

During the above interview, the resident stated he went up front to locate someone to help him get his Oxycodone HCl 5 mg, but he didn't see anyone so he returned to the unit and asked LPN #6 to assist him to apply his ice pack so he could obtain some pain relief, but the nurse gave him a hard time. Resident #310 further stated at 7:00 a.m. LPN #6 came to his room with an improved demeanor, carrying Voltaren cream, Oxycodone HCl 5 mg, two capsules and she told him that the supervisor instructed her to give him the medications. The resident also stated LPN #6 told him to ask the Nurse Practitioner or Physician to schedule his pain medication so he would not be required to request it.

Resident #310 had physician orders dated 3/28/23 for, Acetaminophen Extra Strength 500 mg - Give 2 tablets by mouth three times a day for Pain, Oxycodone HCl 5 mg - Give 1 tablet by mouth every 4 hours as needed for pain related

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to the presence of left artificial knee joint, Oxycodone HCl 5 mg - Give 2 Tablets by mouth every 4 hours as needed for pain related to the presence of left artificial knee joint.

The resident's current care had a problem dated 3/27/23 which read the resident has a risk for pain related to muscle weakness and a left knee total replacement. The goal read the resident's pain will be resolved thru the review period of 6/26/23. The interventions included administering medications as ordered, administering a pain interview as indicated, and notifying MD as indicated.

On 4/3/23 at approximately 1:50 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided, and no further concerns were voiced.

A phone interview was conducted with LPN #6 on 4/6/23 at 12:23 p.m. after the LPN returned a call from 4/3/23. LPN #6 stated she only worked with Resident #310 once and that was on the 11:00 p.m. to 7:00 a.m. shift from 3/30/23 to 3/31/23. LPN #6 stated Resident #310 requested the Oxycodone HCl 5 mg - Give 2 Tablets at approximately 1:00 a.m. for a pain level of "10", and because he had orders for 1 or 2 tablets she asked if he wanted 1 or 2 tablets and he responded "two" therefore he was administered two tablets for pain at a level "10". LPN #6 stated she assessed the resident approximately four hours later and he was asleep, so she documented the Oxycodone HCl 5 mg was effective. LPN #6 stated at approximately 5:00

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F 697	Continued From page 38 a.m. Resident #310 was requesting Oxycodone HCl 5 mg again for pain at a level "10" but he had exhausted his personal supply therefore it would be necessary to notify the pharmacy, obtain a code and a supervisor to access the Oxycodone HCl 5 mg. LPN #6 stated by the time she went through the process to gain access to the medication it was approximately 7:00 a.m. and she also advised the resident to speak with the NP/physician to possibly schedule the medication instead of having it as needed since his routine was to have it every four hours.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700		5/15/23

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F 700	Continued From page 39 by: Based on observation, interview, and record review, the facility failed to ensure that two of two residents (Resident (R) 353 and R354) and/or Resident Representative (RR) reviewed for bed rail use were informed of the risks and benefits, consent for the use of bed rails was obtained, and had documented alternatives to the use of bed rails attempted before rail use. This failure had the potential for residents with bed rails to be uninformed of the risk of severe injury and/or death associated with bed rail use. Findings include: 1. During an observation on 03/28/23 at 1:30 PM, R353 was in bed with bilateral upper bed rails. The RR (RR353) present in room at the time stated no one had advised them of the risks or benefits of having bed rails. Review of R353's "Admission Record," from the facility electronic medical record (EMR) showed a facility admission date of 03/24/23 with medical diagnoses that included rheumatoid arthritis, osteoarthritis, and low back pain. Review of R353's "Care Plan" from the EMR "Care Plan" tab, showed: "SHORT TERM CARE: the resident requires assistance with their activities of daily living due to recent hospitalization, pain, . . . pressure ulcers, pain, pain meds, diuretic use. -the resident will improve in their ability to perform bed mobility movements thru the review period. . . . -1 person assist bed mobility . . . -1/4 rails . . ."	F 700	F 700 Cross ref 12 VAC 5-371 -220 (A) Nursing services 1. Resident #353 no longer resides in the center. Resident #354 had been informed of the risks and benefits of bed rails and has consented to their use to aid in her repositioning and bed mobility. 2. Current residents have the potential to be affected. 3. Staff Development coordinator or designee will educate nurses to assess residents related to potential alternatives to bed rails , to review risks benefits of bed rails and obtain consent for use. 4. Weekly review of all new admissions will be completed to ensure appropriate measures have been implemented to review potential alternatives to bed rails , risk and benefits have been reviewed with resident /responsible party and consent obtained. Issues noted during the review will be presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. 5. Date of completion. 5/15/2023	

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Review of R353's EMR on 03/28/23 at 3:25 PM, the "Misc [Miscellaneous]" and "Assessments" tab did not show a bed rail assessment, risk/benefit notification, or signed informed consent for bed rail usage.

On 03/30/23 at 6:58 PM, the Regional Director of Clinical Services (RDCS) provided a "Device Assessment" section from the 03/28/23 "Admission Assessment" assessment that showed
"A. Type of device
1. Bed rails (assist bars, 1/4, 1/2, 1/8, etc)* . . ." was checked and the determination was for 1/8 rails as an enabler. When asked if the assessment included any documentation of items attempted prior to the use of the rails, the RDCS stated, "They are just assist bars and come attached to the bed." The "Device Assessment" also had checked that RR353 had been advised of the risks and benefits and had consented to the rails.

During a follow-up interview on 03/31/23 at 11:15 AM, both R353 and RR353 stated neither had received information regarding the risks/benefits of rail use, and that neither had signed a consent for rail usage.

2. During an observation and interview on 03/29/23 at 11:11 AM, R354 was noted to have bilateral upper rails on the bed. When asked, R354 stated she had not received any information regarding the risks and benefits of the rails.

Review of R354's "Admission Record" from the EMR "Profile" tab showed a facility admission date of 03/13/23 with medical diagnoses that

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included displaced bicondylar fracture, generalized muscle weakness, and difficulty walking.

Review of R354's admission "Minimum Data Set [MDS]" assessment reference date (ARD) 03/19/23 showed a "Brief Interview for Mental Status [BIMS]" score of 14 out of a possible 15, indicative of being cognitively intact.

A review of R354's EMR on 03/30/23 at 3:35 PM did not reveal an evaluation for rail use in the "MISC" or "Assessment" tabs.

On 03/30/23 at 6:58 PM, the RDCS provided R354's "Admission Assessment," dated 03/14/23, "Bed Side Rail Tool" showing 1/8 side rails were necessary for bed mobility and that R354 had been advised of the risks/benefits and consented to the use of rails.

Review of R354's "Care Plan" from the EMR "Care Plan" tab showed:
"Focus: SHORT TERM CARE: the resident requires assistance with their activities of daily living due to recent fracture, recent hospitalization . . .
Goal: the resident will improve in their ability to ambulate and make turns thru the review period.
Interventions: . . .
grab bars . . ."

During a follow-up interview on 03/31/23 at 10:35 AM regarding if any facility staff had discussed the risks and benefits of bed rails or if she had signed a consent, R354 responded "No" to both, and interjected "but I like them, I use them to roll over."

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F 700	Continued From page 42 In a follow-up interview of 03/31/23 at 3:00 PM, the RDCS confirmed the facility did not have a bed rail policy as they were considered to be mobility aides. During a conversation on 03/31/23 at 6:43 PM regarding if the mobility aides on the beds were considered bed rails, the Administrator affirmed the rails were not larger than 1/8 and that "If it's smaller than 1/8, it's not a bed rail." An observation was completed on 03/31/23 at 6:50 PM with the Maintenance Director (MD) in R354's room where the rail size was measured and found to be 19.5 inches; the bed mattress was measured and found to be 74 inches, and the bed frame (albeit, in a semi fowlers [head of bed elevated about 45 degrees] so the bed contour was attempted to be followed with the measuring tape) was noted to be 78 inches. The Maintenance Director noted it should be an 80 inch bed. At 7:00 PM, the measurements were reviewed, and the Maintenance Director confirmed the findings.	F 700		