STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495431	A. BUILDING _____ B. WING _____	C 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEREA HEALTH & REHAB CENTER	55 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/31/23 through 06/02/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/31/2023 through 6/2/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey (VA00057010-substantiated with no deficiency). The census in this 90 certified bed facility was 69 at the time of the survey. The survey sample consisted of 27 current resident reviews and 7 closed record reviews.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553	F 553 1. Address how corrective action was accomplished for the resident(s) affected. Resident # 18 was invited to participate in a care conference on 6/6/2023 and did attend. 2. Address how the facility will identify other residents with potential to be affected. Administrator reviewed care conferences scheduled in the last 30 days and appropriate invitations were sent to those who did not attend. This was completed by 6/16/23.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/22/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 553	Continued From page 1 other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility record review, it was determined that the facility staff failed to ensure one of 34 residents were provided the opportunity to participate in the care planning process, Resident #18. The findings include: For Resident #18 (R18), the facility staff failed to evidence inclusion of the resident in the interdisciplinary care planning process. On the most recent MDS (minimum data set), an annual admission assessment with an ARD (assessment reference date) of 5/1/2023, the resident scored 15 out of 15 on the BIMS (brief	F 553	3. Address measures to be put in place to ensure deficient practice does not recur. Care Conferences will be scheduled and invitations sent per Saber policy. All department managers have been educated on care conference policy by Administrator/Designee. Education was completed on 6/8/2023. Staff will not be allowed to return to work until they received this education. All new hires involved in this care plan process will receive this education in orientation process starting 6/9/2023. 4. Indicate how facility will monitor performance to ensure solutions are sustained. Administrator will review Care plan conference schedule in the morning meeting to ensure proper invitations for residents have been sent weekly for 12 weeks starting 6/19/23. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23.	

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F 553	Continued From page 2	F 553		

interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

On 6/1/2023 at 2:09 p.m., an interview was conducted with R18 in their room. R18 stated that they had resided at the facility for about a year. When asked if they were invited to participate in the care planning process, R18 stated that they had never been asked to attend a care plan meeting. R18 stated that they would be interested in attending any meeting that discussed their care and goals because they wanted to be involved in their care at the facility.

Review of R18's clinical record failed to evidence documentation of care plan meeting notes or invitations provided to R18.

On 6/1/2023 at 3:18 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for evidence of R18 being invited and/or notified of the care plan meetings.

On 6/1/2023 at 3:44 p.m., ASM #2 stated that they did not have evidence of a care plan invitation/notification for R18 to provide.

On 6/2/2023 at 9:05 a.m., an interview was conducted with OSM (other staff member) #6, the director of social services. OSM #6 stated that they set up the care plan meetings every quarter and annually. OSM #6 stated that they normally provided telephone notice to the residents responsible party if applicable and spoke to the residents in person and gave them an invitation letter. OSM #6 stated that they documented the invitation in the progress notes, however they did not have evidence of that for R18. OSM #6

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F 553	Continued From page 3 stated that they were not having care plan meetings as often for a while because there really was no nursing department so they were meeting with the MDS coordinator. OSM #6 stated that they had met with R18's sister a couple of times and met with R18 directly a couple of times in the past. The facility policy, "Comprehensive Care Planning Policy" with a revision date of 7/19/2019 documented in part, "...The Interdisciplinary Care Planning Team may consist of: 1. The resident, the resident's family and/or the resident's legal representative.... The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation (original) is presented to the resident at least five (5) days prior to the date of conference. A designated time of meeting is given to each resident. (Those residents who have been deemed legally incompetent or has documentation in their medical record, as medically incompetent by their attending physician would be exempt from this procedure.) A copy of the letter is maintained for reference..." On 6/1/2023 at 4:38 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the above concern. No further information was presented prior to exit.	F 553		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580		

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F 580	Continued From page 4 consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility	F 580	F 580 1. Address how corrective action was accomplished for the resident(s) affected. Resident # 65 is no longer in the facility. 2. Address how the facility will identify other residents with potential to be affected. All residents who have had a significant change have the potential to be affected. DON/ designee conducted a quality review of records for residents with changes in condition in the past 72 hours as of 6/6/23. DON/ designee educated nurses where discrepancies were noted. All residents who currently reside in the facility with discrepancies were discussed with the provider with no negative outcomes noted.	

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F 580	Continued From page 5 that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). 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 immediately notify the physician of a significant change in condition for one of 34 residents, Resident #65, which constituted harm. The findings include: For Resident #65, the facility staff failed to immediately notify the physician of a significant change in oxygen saturation. Your blood oxygen level (blood oxygen saturation) is the amount of oxygen you have circulating in your blood (1). Resident #65 was admitted to the facility on 10/28/22 with diagnosis that included but were not limited to: CVA (cerebral vascular accident), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), CKD (chronic kidney disease), DM (diabetes mellitus), Cirrhosis of Liver and acute and chronic respiratory failure with hypoxia. A review of the comprehensive care plan dated 10/30/22 revealed, "FOCUS: At risk for altered cardiac /respiratory status. anemia, CAD (coronary artery disease), hyperlipidemia, pulmonary HTN (hypertension), COPD, with acute and chronic respiratory failure with hypoxia,	F 580	3. Address measures to be put in place to ensure deficient practice does not recur. DON/ designee educated licensed nurses on requirements to notify MD of a significant change in condition. Education was completed on 6/8/2023. Staff will not be allowed to return to work until they received the education. Education will be included in new hire orientation as well as agency orientation effective 6/9/2023. 4. Indicate how facility will monitor performance to ensure solutions are sustained. DON/ designee will audit resident records/incident notes for MD notification during morning meeting x12 weeks starting 6/19/2023. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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pleural effusion, patent foramen ovale and GERD (gastro-esophageal reflux disease).
INTERVENTIONS: 02 as ordered. Monitor for signs/symptoms of decreased cardiac output, rapid, slow, weak or diminished pulse, hypo/hypertension, dizziness, syncope, dyspnea, chest pain, fatigue, restlessness, cyanosis, altered mental status, congestion and shortness of breath. Notify physician as needed with any changes."

A review of the physician's orders dated 10/28/22, revealed, "4L (liters) continuous oxygen NC (nasal cannula) - check setting every shift and on rounds everyday shift for O2 (oxygen) Saturation.

A review of the facility's "Standing Orders" revealed, "Shortness of breath (SOB)/difficulty breathing: may place oxygen at 2 liters/minute via nasal cannula as needed for SOB or saturation below 89%. If oxygen saturation less than 87% with difficulty breathing, obtain stat chest x-ray and call physician STAT (immediately). Transfer: In case of an emergency when attending physician is unable to be reached, you may transfer to hospital."

A review of the nursing progress note, dated 4/22/23 at 8:03 AM included, "Note Text: Resident was seen lethargy, with an oxygen level of 70% at room air during change of shift. resident was repositioned and 15 liter oxygen was administer via non-rebreather mask. resident O@ [sic] went up to 97 % and resident was responsive and having conversion with staff. resident called her full name and was able to identify where she was. O2 level was reduced to 10 liter via non-rebreather mask after resident became stable, alert and oriented X4 and verbally

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responsive. resident was being monitored every 1 hr. resident retained an oxygen level of 94 to 97% on a simple mask with o2 at 8Lmp. at 0400 resident verbalized abdominal pain and was given hydromorphone 2mg which was effective. at this time, writer called (physician hospital group) on-called [sic] and was awaiting a call back to discuss resident's condition with the DR. but to no avail. at 5 am, resident was stable and resting in bed with an O2 level of 94% via simple mask. at 0540, resident was seen unresponsive. there was no pulse or respiration noted. Writer began CPR and another nurse called 911. 911 arrived at about 0559 and began high pressure CPR. resident could not be resuscitated and was pronounce [sic] dead at about 0626. Resident is he [sic] own responsible party..."

An interview was conducted on 6/3/23 at 8:55 AM, with RN (registered nurse) #3. When asked what would be change of condition indicators for physician notification, RN #3 stated, "We would call the physician for grossly abnormal vital signs, any change in baseline, altered mentation, oxygen saturation level below 90-95%."

An interview was conducted on 6/3/23 at 9:05 AM, with LPN (licensed practical nurse) #4. When asked what would be change of condition indicators for physician notification, LPN #4 stated, "We would notify the physician for abnormal vital signs, change in mentation, oxygen saturation less than 91%. Blood sugar changes and would initiate standing orders if applicable. Call the physician and if no response from the physician or condition worsens immediately call 911."

An interview was conducted on 6/3/23 at 9:10 AM

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F 580	Continued From page 8 with ASM (administrative staff member) #4, the nurse practitioner (NP). When asked when should the NP be notified for oxygen saturation, ASM #4 stated, "We should have been notified for anything less than 87% per the standing orders. We did not receive notification to my knowledge." When asked what are the maximum oxygen liters per minute for a COPD resident, ASM #4 stated, "It is 4-5 liters per minute." An interview was conducted on 6/2/23 at 9:49 AM with RN (registered nurse) #2, who was the nurse on duty at the time of the event. When asked to describe the events of 4/21/23-4/22/23 with Resident #65, RN #2 stated, "I got there late, between 11:30 PM-12:00 AM on 4/21/23. I made my rounds and the resident was laying across the bed. Her oxygen (O2) was not on. She was lethargic. Her vital signs were normal and O2 saturation was low about 77-78%. I increased her to 15 LNC (liters nasal cannula), got her situated and her O2 saturation came up to 92-93%. Then she was alert and oriented." RN #2 stated, "I kept monitoring her oxygen and trying to decrease it. I could not get it back to 4 LNC because her saturation would drop. I had her on a rebreather and finally got her down to 8 liters. I told her that I have to send her to the hospital. She did not want to go. She started having stomach pain, so I gave her narcotic for the pain." RN #2 stated, "At 4:00 AM, I called the hospital doctor exchange. I did not get a call back. I called the DON (director of nursing) to let her know of the situation. Resident was reassessed with O2 saturation in 90's on the 8 L face mask. About 5:00 AM, I called the hospital doctor exchange again, talked to resident, and said I have to send you out but the Resident refused to go." RN #2 added, "I was the only	F 580		

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F 580	Continued From page 9	F 580		

nurse on the unit, with one CNA...around 5:40 AM, I went to check on (Resident #65) and she was unresponsive. I put her on the floor and started CPR (cardiopulmonary resuscitation)." When asked if there were orders to adjust the oxygen, RN #2 stated, "No, there was no order. We have standing orders, but they do not cover higher oxygen. I could not keep her on that low oxygen rate. That's the reason I called the physician exchange and the DON. The resident was stable on the higher oxygen, she was not critical at the time, so I did not call 911. I did my due diligence and got her oxygen saturation back up by increasing her oxygen level."

There was no evidence in the clinical record regarding the second attempt to call to the on-call physician or that the resident refused to go to the hospital.

An interview was conducted on 6/2/23 at 11:10 AM with ASM #7, the medical director. When asked if the physician should be notified for an O2 saturation of 70%, ASM #7 stated, "Yes, of course. I expect the staff to call 911 and send the resident to the hospital like we do during the day. Patient safety is the first thing."

On 6/2/23 at approximately 11:35 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services was made aware of the findings and concern for harm.

On 6/2/23 at 11:37 AM, an interview was conducted with ASM #2, the director of nursing, who stated, "The nurse called me around 6:00 AM and said the EMTs (emergency medical

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F 580	Continued From page 10 technicians) were there and CPR was being done. I do not believe I was called at 4:00 AM. I do not remember the nurse saying she could not reach the on-call physician. I was not aware this had been going on for hours." During the survey, three other residents, Residents #58, #60 and #272 were assessed to confirm physicians were notified of a significant change in condition. Two residents, Residents #58 and #60 were transferred to the hospital and returned to the facility with no concerns regarding care they were provided. Resident #272 was placed on hospice and expired in the facility. No pattern of failure to notify a physician for a significant change in condition was found. A review of the facility's "Resident Change in Condition" policy dated 7/2021, revealed, "The licensed nurse will recognize and intervene in the event of a change in resident condition. The Physician/Provider and the Family/Responsible Party will be notified as soon as the nurse has identified the change in condition and the resident is stable. The Nurse will address any emergency care required given the situation and then gather information prior to contacting the physician/provider. If, after discussion with the physician/provider, the care or observation cannot reasonably be provided in the facility, the physician will authorize transfer to the hospital or alternative facility. If the attending or covering physician/provider does not respond in a timely manner, the nurse will notify the Medical Director for guidance, consultation, and orders. In the event of an emergency situation, 911 will be called immediately and the Physician or Provider/Family/Responsible Party will be notified as soon as practicably possible."	F 580		

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F 580	Continued From page 11 No further information was provided prior to exit. Reference: (1) https://my.clevelandclinic.org/health/diagnostics/22447-blood-oxygen-level	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;	F 622	F 622 1. Address how corrective action was accomplished for the resident(s) affected. Resident #15 and #58 currently reside in the facility. Nurses present during discharge for resident #15 and #58 was educated on the requirements of transfer/discharge to hospital. No negative outcomes occurred to either resident. 2. Address how the facility will identify other residents with potential to be affected. Any resident who is currently in the hospital has the potential to be affected. There are no residents currently in the hospital during audit on 6/9/2023. 3. Address measures to be put in place to ensure deficient practice	

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	495431	A. BUILDING _____ B. WING _____	C 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEREA HEALTH & REHAB CENTER	55 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

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F 622	Continued From page 12 or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of	F 622	does not recur. The DON/ designee will educate licensed nurses on the requirements for unplanned hospital transfers documentation requirements. Education was completed on 6/8/2023. Staff will not be allowed to return to work until they received this education. Education will be included in new hire orientation as well as agency orientation effective 6/9/2023. 4. Indicate how facility will monitor performance to ensure solutions are sustained. The DON/ designee will audit all hospital transfers in the morning meeting for the next 12 weeks starting 6/19/23. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 622	Continued From page 13 this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide the required documentation upon transfer to the hospital for two of 34 residents in the survey sample, Residents #15 and #58. The findings include: 1. For Resident #15 (R15), the facility staff failed to provide the care plan goals to the receiving facility on 3/4/2023. A nurse's note dated, 3/4/2023 at 7:22 p.m. documented in part, "Patient was transported to (initials of hospital) ER (emergency room) as ordered by (name of doctor) approximately 9:15 this evening. EMS (emergency medical services) provided with face sheet, med (medical) hx (history) and med (medication) list. (Initial of hospital) also called and report given to the	F 622		

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F 622	Continued From page 14 charge nurse on duty." An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/2023 at 1:59 p.m. When asked what paperwork is sent with the resident when they are transferred to the hospital, LPN #4 stated, the care plan, bed hold, medication list, last doctor or nurse practitioner note, any recent laboratory tests or x-ray results." LPN #4 was asked where a nurse documents what was sent, LPN #4 stated in the progress notes. The facility policy, "Discharge Planning Policy," documented in part, "6. Information to the Receiving Provider. Information provided to the receiving provider must include a minimum of the following: a. Contact information of the practitioner responsible for the care of the resident. b. Resident representative information including contact information. c. Advance Directive information. d. All special instructions or precautions for ongoing care, as appropriate. e. Comprehensive care plan goals. f. All other necessary information, including a copy of the residents discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m. No further information was provided prior to exit.	F 622		

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F 622	Continued From page 15 2. For Resident #58 (R58), the facility staff failed to evidence documentation of all required paperwork sent to the receiving facility upon transfer on 4/11/2023. The nurse's note dated 4/11/2023 at 8:23 a.m. documented in part, "Order received form (name of nurse practitioner) to send resident to ER for left side weakness and non-verbal and the residents needs can no longer be met in the facility. Resident has been notified that she will be going to the ER and the reasons that she is going, pt (patient) is unable to understand that she is going, bed hold and care plan goals sent with the resident. Resident RP (responsible party) also notified of the above and of all the document that accompanied the resident." An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/2023 at 1:59 p.m. This is the nurse that wrote the above note. When asked what paperwork is sent with the resident when they are transferred to the hospital, LPN #4 stated, the care plan, bed hold, medication list, last doctor or nurse practitioner note, any recent laboratory tests or x-ray results." LPN #4 was asked where a nurse documents what was sent, LPN #4 stated in the progress notes. The above nurse's note was reviewed with LPN #4. When asked if she documented all the documents sent with the resident, LPN #4 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m.	F 622		

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F 622	Continued From page 16 No further information was provided prior to exit.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a bed hold notice upon transfer to the hospital for one of 34	F 625	F 625 1. Address how corrective action was accomplished for the resident(s) affected. . Resident #15 currently resides in the facility. Nurses present during discharge for resident #15 was educated on the requirements of bed hold policy. No negative outcomes occurred to either resident. 2. Address how the facility will identify other residents with potential to be affected. Any resident who is currently in the hospital has the potential to be affected. There were no residents in the hospital during the audit on 6/9/2023.	

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F 625	Continued From page 17 residents in the survey sample, Resident #15. The findings include: For Resident #15, the facility staff failed to provide a bed hold notice upon transfer to the hospital on 3/4/2023. The nurse's note dated, 3/4/2023 at 7:22 p.m. documented in part, "Patient was transported to (initials of hospital) ER (emergency room) as ordered by (name of doctor) approximately 9:15 this evening. EMS (emergency medical services) provided with face sheet, med (medical) hx (history) and med (medication) list. (Initial of hospital) also called and report given to the charge nurse on duty." An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/2023 at 1:59 p.m. When asked what paperwork is sent with the resident when they are transferred to the hospital, LPN #4 stated, the care plan, bed hold, medication list, last doctor or nurse practitioner note, any recent laboratory tests or x-ray results." LPN #4 was asked where a nurse documents what was sent, LPN #4 stated in the progress notes. The facility policy, "Bed Hold Letter Policy," documented in part, "Business Office or designee will complete the Medicaid Bed Hold Letter and send to the appropriate parties' certified/return receipt requested. The Medicaid Bed Hold Letter can be given directly to the responsible party if they are present. Medicaid Copy will be retained in resident's financial file." This policy provided did not address sending a bed hold notice with a resident upon transfer to the hospital.	F 625	3. Address measures to be put in place to ensure deficient practice does not recur. The DON/ designee will educate licensed nurses on the requirements for bed hold policy upon transfer to the hospital. Education was completed on 6/8/2023. Staff will not be allowed to return to work until they received this education. Education will be included in new hire orientation as well as agency orientation effective 6/9/2023. 4. Indicate how facility will monitor performance to ensure solutions are sustained. The DON/ designee will audit hospital transfers/discharges in morning meeting x 12 weeks starting 6/19/23 to verify required bed hold policy has been provided. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 625	Continued From page 18 ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m. No further information was provided prior to exit.	F 625		
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 and clinical record review, it was determined the facility staff failed to accurately complete two MDS (minimum data set) assessments for one of 34 residents in the survey sample, Resident #24. The findings include: For Resident #24 (R24), the facility staff failed to accurately code the resident's cognition on two MDS assessment. The admission MDS assessment, with an assessment reference date (ARD) of 1/30/2023 in Section B - Hearing Speech and Vision, coded the resident as being rarely/never understood by others and rarely/never understands when spoken to. In Section C - Cognitive Patterns, R24 was documented, "Should Brief Interview for Mental Status be conducted?" A "1" was documented indicating the interview should be conducted. A "0" would indicate the resident is	F 641	F-641 1. Address how corrective action was accomplished for the resident(s) affected. A new MDS for Resident # 24 was set with an ARD of 6/21/23 to include an accurate section C. Resident did not have any negative impact and continues to reside in the facility. 2. Address how the facility will identify other residents with potential to be affected. All residents have the potential to be affected. Social Services conducted a 100% audit of section C on all residents' on 6/6/2023 for MDS accuracy and MDS nurse verified the audit was accurate. There were no other negative findings.	

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F 641	Continued From page 19 rarely/never understood - skip to staff assessment for mental status. The Resident interview was conducted, and the resident scored a "00 out of 15," indicating the resident was severely cognitively impaired for making daily decisions. The staff assessment for mental status was not completed. The quarterly MDS assessment, with an ARD of 5/2/2023 in Section B - Hearing Speech and Vision, coded the resident as being rarely/never understood by others and rarely/never understands when spoken to. In Section C - Cognitive Patterns, R24 was documented, "Should Brief Interview for Mental Status be conducted?" A "1" was documented indicating the interview should be conducted. A "0" would indicate the resident is rarely/never understood - skip to staff assessment for mental status. The Resident interview was conducted, and the resident scored a "00 out of 15," indicating the resident is severely cognitively impaired for making daily decisions. The staff assessment for mental status was not completed. An interview was conducted with RN (registered nurse) #1 on 6/1/2023 at 1:08 p.m. When asked who completes Sections B and C of the MDS, RN #1 stated she completes Section B and the social worker completes Section C. The above MDS assessments were shared with RN #1. RN#1 stated according to the RAI (resident assessment instrument) manual, if a resident is coded as rarely/never under understood, the staff assessment should be completed. RN #1 was asked if the above MDS assessments were coded correctly, RN #1 stated, no. An interview was conducted with OSM (other staff	F 641	3. Address measures to be put in place to ensure deficient practice does not recur. Social Services staff was reeducated by the Regional Director of Clinical Services on coding accuracy of MDS with emphasis on Section C coding. Education was completed on 6/8/2023. Any new hires involved in this MDS process will receive this education in orientation process starting 6/9/2023. 4. Indicate how facility will monitor performance to ensure solutions are sustained. MDS/Designee will audit MDS per the quarterly calendar weekly x 12 weeks starting 6/19/23 for MDS accuracy of coding of section C. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 641	Continued From page 20 member) #6, the social worker, on 6/1/2023 at 1:16 p.m. When asked if R24 can be understood and can she understand, OSM #6 stated she sometimes speaks but not very often. "Hi" is about all they say, not much more than that. The above MDS assessments were reviewed with OSM #6. OSM #6 was asked if Section C - Cognitive Patterns is coded accurately, OSM #6 stated, no. The "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 20192, documented in part, "Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700-C1000, Staff Assessment of Mental Status." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m. 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	F 656	F – 656 1.Address how corrective action was accomplished for the resident(s) affected. a .Resident # 56 was provided a communication board to ensure care plan is correct on 6/9/23. Resident #56 was provided an activities calendar in their native language 6/5/23. Resident #56 remains in the facility with no obvious negative impact. b. Resident #59s oxygen flowrate was adjusted to reflect physicians order upon discovery on 6/1/23 during the survey. Resident #59 remains in the facility with no obvious negative impact.	

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F 656	Continued From page 21 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to 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, resident interview, staff interview, clinical record review, and facility	F 656	c. An audit of resident # 18 medications and orders was conducted by DON/designee and all medications were available to be administered as ordered on 6/6/2023. The MD was notified of failing to administer medications to resident per physician's orders and no new orders were received. Resident currently resides in facility with no negative outcomes. d. The resident # 65 is no longer in the facility.	

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F 656	Continued From page 22 document review, it was determined that the facility staff failed to implement the comprehensive care plan for five of 34 residents, Residents #56, #59, #18, #65, and #22. The findings include: 1. For Resident #56 (R56) the facility staff failed to implement the comprehensive care plan to A) teach the resident how to use communication devices and B) provide leisure supplies in the residents primary language. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/13/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. Section B documented R56 having moderate difficulty with hearing and wearing hearing aids. It also documented R56 having impaired vision, wearing corrective lenses and able to see large print but not regular print. Section F documented having books, newspapers and magazines to read and participating in religious services or practices somewhat important to them. It documented a resident representative completing the assessment for the resident. On 5/31/2023 at 1:02 p.m., R56 was observed sitting in a wheelchair in their room listening to the radio. At this time an interview was attempted with R56. R56 stated, "No English." R56 proceeded to pick up their cell phone and attempted to make a call with no answer. No communication tools were observed in R56's room. No leisure supplies in the residents primary language were visible in the room.	F 656	e. 30 days of visit summaries from dialysis center were obtained for resident #22 and scanned into their electronic medical record (EMR). NP notified of the missed medication order and stated to start the medication, order processed per script. Summaries were reviewed and any new orders were processed. The MD was notified of failing to administer a treatment to resident per physician's orders with no new orders on 5/31/23. The skin prep treatment was discontinued on 6/14/23 due to heels having no redness. Resident continues to reside in the facility and had no negative outcomes.	

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F 656	Continued From page 23 On 5/31/2023 at 2:28 p.m., an interview was conducted with R56's granddaughter who was visiting in the room. When asked how the staff communicated with (R56), they stated that they were unsure. R56's granddaughter stated that R56 knew a few words, could point to things and staff would call them as needed. R56's granddaughter stated that they were not aware of any type of communication tools that the facility staff used. (A) The facility staff failed to implement the care plan to teach the resident how to use communication devices. The comprehensive care plan for R56 documented in part, "Inability to express emotion, listen and share information. Alteration in communication related to: hearing deficit, Language barrier, blindness. Date Initiated: 03/08/2023. Created on: 02/15/2023." Under "Interventions" it documented in part, "...Teach resident how to use communication book/ board/ electronic device. Date Initiated: 03/08/2023. Created on: 02/15/2023..." The progress notes for R56 documented in part, - "2/15/2023 19:31 (7:31 p.m.) Note Text : IDT (interdisciplinary) team notified by family member of resident's hard of hearing, blindness and language barrier. Resident speaks Hungarian. Assistive devices in use: Resident's has hearing aides. Communication board offered to resident- resident's son requests that facility calls him for interpretation. Son visits everyday- requests that son's number is placed by bedside wall." - "2/26/2023 10:55 (10:55 a.m.) Nursing note...residents' primary language is not English,	F 656	2. Address how the facility will identify other residents with potential to be affected. a. All residents who require a communication board have the potential to be affected. On 6/8/2023 the DON/ designee assessed all residents to ensure any needs for communication devices are being met. All discrepancies were corrected at that time. b. Any resident requiring oxygen treatments has the potential to be affected. DON/ designee conduced an audit of residents requiring oxygen and nebulizers and completed on 6/7/2023 to verify oxygen is at prescribed flowrate and care plan was followed. c. All residents have the potential to be affected by this deficiency. On 6/7/2023 a report of all medication omissions was reviewed by DON/ designee for the last 7 days to ensure no medications were omitted due to unavailability. Any negative findings were followed-up with provider notification. No further orders were given.	

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F 656	Continued From page 24 daughter was able to help resident communicate needs during shift..." - "3/19/2023 12:22 (12:22 p.m.) Nursing note...Resident is alert and oriented x 4 (person, place, time and situation) but does have difficulty expressing needs due to language barrier. Resident uses body language many times to express needs, which is effective..." - "3/23/2023 22:58 (10:58 p.m.) Nursing note...Resident is alert and oriented x 3 (to person, place and time), with language barrier. Resident's primary language is Hungarian. Resident is able to say a few words in English to communicate needs, and uses body language to communicate. Resident's family does provide assistance with translating..." - "4/4/2023 18:13 (6:13 p.m.) Nursing note...Some language barriers, but able to make needs known to staff..." - "4/6/2023 13:41 (1:41 p.m.) This writer observed that resident began to cry and became very emotional after son stated resident will remain LTC (long term care) due to the increased amount of assistance with ADLs (activities of daily living). Resident stated in native language that she feels lonely and does not have companionship due to language barrier. Son has been coming in to visit resident every day and is communication with nursing staff/SW (social worker). Son has advised to always call him for translation. SS (social services) will assist in finding LCAs, organizations/groups that speak Hungarian/Romanian for resident companionship. Resident and resident's son agrees." On 6/02/2023 at 8:52 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was for them to administer patient care and it	F 656	c. All residents have the potential to be affected by this deficiency. On 6/7/2023 a report of all medication omissions was reviewed by DON/ designee for the last 7 days to ensure no medications were omitted due to unavailability. Any negative findings were followed-up with provider notification. No further orders were given. d. Same as b. e. Any resident receiving dialysis services has the potential to be affected. On 6/7/2023 a review current residents was completed by DON/ designee and no other residents are currently residing in the facility who receive dialysis services. Address how the facility will identify other residents with potential to be affected. All residents have the potential to be affected by this deficiency. On 6/15/2023 a report of all treatment omission was reviewed by DON/ designee for the last 14 days to ensure no treatments were omitted. Any negative findings were followed-up with provider notification. No further orders were given.	

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F 656	Continued From page 25 showed them what they needed to do for the patient and the goals. LPN #1 stated that the care plan was implemented by them doing what it said for them to do on it. LPN #1 stated that they were not aware of R56 having any communication devices. On 6/2/2023 at 8:48 a.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that R56 used hand gestures, nodded their head and gives them the thumbs up to communicate. CNA #4 stated that R56 understood limited English and could point to the juice, coffee and water to make decisions. CNA #4 stated R56 did not have any communication devices because they could speak but could not speak English. On 6/2/2023 at 8:58 a.m., an interview was conducted with OSM (other staff member) #8, life enrichment. OSM #8 stated that they had taken their communication board when they went to visit with R56 but they did not leave it in the room. OSM #8 stated that they thought that perhaps social services was working on setting up a personalized communication board for R56. On 6/2/2023 at 9:05 a.m., an interview was conducted with OSM # 6, the director of social services. OSM #6 stated that they had requested R56's son to set up a communication board and the director of rehab was working with them. OSM #6 stated that they had discussed this about a month ago. OSM #6 stated that they had reached out to a few organizations and were still trying to find churches in the area that may offer volunteers to come to the facility for R56. On 6/2/2023 at 9:17 a.m., an interview was	F 656	3. Address measures to be put in place to ensure deficient practice does not recur. The DON/ designee will educate licensed nurses on implementing the care plan with an emphasis on communication, oxygen, dialysis, and administering medication and treatments. Staff will not be allowed to return to work until they received this education. Education will be completed by 6/20/2023. Any new hires involved in this process will receive this education in orientation process starting 6/20/2023.	

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F 656	Continued From page 26 conducted with OSM #5, the director of rehab services. OSM #5 stated that they were not technically working on setting up a communication board for R56. OSM #5 stated that they had spoken to R56's son who stated that they would work with activities to facilitate a communication board. OSM #5 stated that they were told by the former activities director that R56's son did not comply with setting up the communication board. OSM #5 stated that it was not the families responsibility to facilitate the communication devices that it was the facilities. On 6/2/2023 at approximately 9:30 a.m., a request was made to ASM (administrative staff member) #3, assistant director of nursing, for evidence of facility interventions regarding communication devices attempted with R56. On 6/2/2023 at approximately 10:10 a.m., ASM #2, the director of nursing provided the progress note dated 2/15/2023 documented above. On 6/2/2023 at approximately 11:00 a.m., a follow up interview was conducted with OSM # 6, the director of social services. When asked about the progress note provided dated 2/15/2023, OSM #8 stated that R56's son had declined the communication board that they offered on 2/15/23. OSM #6 stated that R56's son did not really state why he declined the communication board other than it would not work. OSM #6 provided the communication board from their desk, a laminated page approximately 8.5 x 11 inches in size with large pictures of ADL tasks with the English words written underneath. OSM #6 stated that R56 was blind and hard of hearing. When asked if R56 was legally blind and could feed themselves, OSM #6 stated, "Yes." When	F 656	4. Indicate how facility will monitor performance to ensure solutions are sustained. DON/ designee will audit 5 resident care plans with regards to oxygen rates, communication devices, dialysis, administering medication and treatments weekly x 12 weeks to ensure all interventions are being implemented starting 6/19/2023. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 656	Continued From page 27 asked if R56 would be able to see a communication board, OSM #6 stated, "Yes." OSM #6 stated that this conversation was with R56's son when R56 was at the facility for short-term rehabilitation and they had not had any conversations or approached the subject with the son or the resident since the decision had been made to stay at the facility long term. OSM #6 stated that they had not had a care plan meeting since the transition to long term care but it was scheduled this month. (B) The facility staff failed to implement the care plan to provide leisure supplies in Hungarian due to a language barrier. The comprehensive care plan for R56 documented in part, "Resident has a variety of leisure interests but prefers to participate in self-directed leisure. Date Initiated: 03/08/2023. Created on: 02/15/2023." Under "Interventions" it documented in part, "Resident will be given leisure supplies in Hungarian due to language barrier. Date Initiated: 03/08/2023. Created on: 02/15/2023..." The progress notes for R56 failed to evidence documentation of leisure supplies provided in R56 primary language. On 6/02/2023 at 8:52 a.m., an interview was conducted with LPN #1. LPN #1 stated that the purpose of the care plan was for them to administer patient care and it showed them what they needed to do for the patient and the goals. LPN #1 stated that the care plan was implemented by them doing what it said for them to do on it. LPN #1 stated that R56 did not speak English but knew a few words and could make	F 656		

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F 656	Continued From page 28 hand gestures to communicate what they needed. On 6/2/2023 at 8:58 a.m., an interview was conducted with OSM (other staff member) #8, life enrichment. OSM #8 stated that they worked with R56 and provided activities like doing their nails and taking them outside. OSM #8 stated that they had attempted to get them to participate in group activities but they had refused by shaking their head "no." OSM #8 stated that they had not provided any books or magazines for R56 in Hungarian but that it was a good idea. OSM #8 stated that they were not aware that the intervention "Resident will be given leisure supplies in Hungarian due to language barrier" was on the care plan and that the former activities staff member had written it. The facility policy, "Comprehensive Care Planning Policy" with a revision date of 7/19/2019 documented in part, "The facility must develop a comprehensive Person Centered Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments...All staff must be familiar with each resident's Care Plan and all approaches must be implemented..." On 6/2/2023 at 12:42 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 2. For Resident #59 (R59), the facility staff failed	F 656		

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F 656	Continued From page 29 to implement the care plan to administer oxygen at the prescribed rate. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/20/2023, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section O documented R59 received oxygen at the facility. On 5/31/2023 at 12:56 p.m., R59 was observed in bed wearing an oxygen cannula. The oxygen was observed to be dated 5/22 and was set at a rate of 2.5 lpm (liters per minute). Additional observations were made of R59 on 5/31/2023 at 4:10 p.m. and 6/1/2023 at 8:48 a.m. wearing the oxygen cannula with the rate at 2.5 lpm. The comprehensive care plan for R59 documented in part, "At risk for altered cardiac/resp (respiratory) status related to aortic stenosis, CAD (coronary artery disease), "white coat syndrome." Date Initiated: 03/31/2023. Revision on: 04/05/2023..." Under "Interventions" it documented in part, "O2 (oxygen) as ordered..." The physician orders for R59 documented in part, "Oxygen: via NC (nasal cannula) at 3L (liters) to maintain SPO2>90% (oxygen saturation greater than 90%), SPO2 check Q (every) shift, every shift. Order Date: 05/31/2023." On 6/1/2023 at 11:35 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that oxygen was checked every	F 656		

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F 656	Continued From page 30 day and administered at the rate based on the order. LPN #1 stated that the flowmeter ball should be centered on the line for the number of the ordered rate. LPN #1 stated that when they checked the rate of the oxygen they read it at eye level. LPN #1 observed R59's oxygen and stated that it was set at 2 lpm. LPN #1 reviewed the order for R59's oxygen and stated that it was ordered at 3 lpm and someone must have set it wrong. On 6/02/2023 at 8:52 a.m., an interview was conducted with LPN #1. LPN #1 stated that the purpose of the care plan was for them to administer patient care and it showed them what they needed to do for the patient and the goals. LPN #1 stated that the care plan was implemented by them doing what it said for them to do on it. LPN #1 stated that if the care plan said to administer oxygen as ordered, then that was what they did to implement the care plan. On 6/1/2023 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 3. For Resident #18 (R18), the facility staff failed to implement the care plan to administer medications as ordered in March and April of 2023. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/1/2023, the resident scored 15 out of 15 on the BIMS (brief interview for	F 656		

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mental status) indicating they were cognitively intact for making daily decisions.

On 5/31/2023 at 12:07 p.m., an interview was conducted with R18 in their room. R18 stated that the nurse's frequently ran out of their medications. R18 stated that they kept track of the medications that they took and how many so they noticed if there was less than the normal amount in the cup when they brought it in the room and questioned the nurses. R18 stated that it happened with multiple medications including their Parkinson's medications, vitamins, supplements and heartburn medication. R18 stated that the nurses told them that they were out of the medication or they could not find it.

The comprehensive care plan for R18 documented in part, "The resident is on Antibiotic Therapy r/t (related to) UTI suppression. Date Initiated: 07/14/2022. Revision on: 02/24/2023." Under "Interventions" it documented in part, "Administer medications as ordered. Date Initiated: 07/14/2022. Revision on: 09/01/2022..." The care plan further documented, "The resident has Parkinson's Disease, restless leg syndrome, and neuropathy related to DM (diabetes mellitus). Date Initiated: 01/31/2023. Revision on: 01/31/2023." Under "Interventions" it documented in part, "Give medications as ordered by the physician. Monitor/document side effects and effectiveness. Date Initiated: 07/13/2022..."

A review of R18's clinical record revealed the following physician's orders:
- "Pantoprazole Sodium Tablet Delayed Release 40 MG (milligram) Give 1 tablet by mouth two times a day for gerd (gastroesophageal reflux

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disease). Order Date: 01/08/2023."
- "Calcitonin (Salmon) Nasal Solution 200 UNIT/ACT (Calcitonin (Salmon)) 1 spray Alternating nostrils one time a day for compression fracture alternate nostrils daily. Order Date: 02/06/2023."
- "Nitrofurantoin Macrocrystal Capsule 50 MG Give 2 capsule by mouth at bedtime for Chronic UTI (urinary tract infection) Suppression. Order Date: 02/23/2023."
- "Ocuvite-Lutein Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for supplement. Order Date: 01/08/2023."
- "Ropinirole HCl ER (extended release) Tablet Extended Release 24 Hour 12 MG Give 1 tablet by mouth at bedtime for restless leg syndrome. Order Date: 01/08/2023."
- "Carbidopa-Levodopa Tablet 25-100 MG Give 2 tablet by mouth three times a day for Parkinson's disease. Order Date: 02/07/2023."

A review of R18's March 2023 eMAR (electronic medication administration record) failed to reveal evidence that Ocuvite-Lutein was administered on 3/28/2023 at 9:00 a.m., Ropinirole 12 mg on 3/9/2023 at 9:00 p.m., Nitrofurantoin 50 mg on 3/22/2023 at 9:00 p.m., and Calcitonin nasal solution on 3/6-3/8/2023 at 9:00 a.m., 3/13-3/15/2023 at 9:00 a.m. and 3/22/2023 at 9:00 a.m.

A review of R18's April 2023 eMAR failed to reveal evidence that Pantoprazole 40 mg was administered on 4/26/2023 at 8:00 a.m. and 4/28/2023 at 8:00 a.m. The eMAR failed to reveal evidence that Carbidopa-Levodopa tablet 25-100 mg was administered on 4/21/2023 at 9:00 a.m. and 1:00 p.m. A review of the eMAR

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note dated 4/21/2023 08:08 (8:08 a.m.) and 15:36 (3:36 p.m.) documented, "Med on order will administer once arrived."

On 6/1/2023 at 11:35 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a resident's medication was not available they checked the extra storage on the medication cart and medication room. LPN #1 stated that if the medication was not available in house they contacted the pharmacy to deliver the medication stat. LPN #1 stated that if they were unable to get the medication delivered stat, they contacted the physician for an alternate order or hold order. LPN #1 stated that if the resident was out of the medication the nurse should call the physician to notify them that the dosage was missed and document in the eMAR notes.

On 6/02/2023 at 8:52 a.m., an interview was conducted with LPN #1. LPN #1 stated that the purpose of the care plan was for them to administer patient care and it showed them what they needed to do for the patient and the goals. LPN #1 stated that the care plan was implemented by them doing what it said for them to do on it. LPN #1 stated that if the care plan said to administer medications as ordered, then that was what they did to implement the care plan.

On 6/1/2023 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were made aware of the above concern.

4. For Resident #65, the facility staff failed to follow the comprehensive care plan for oxygen

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F 656	Continued From page 34 administration and physician notification for a change in condition. Resident #65 was admitted to the facility on 10/28/22 with diagnosis that included but were not limited to: CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), acute and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 2/7/23, 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. MDS Section O-special procedures coded oxygen as 'yes'. A review of the comprehensive care plan dated 10/30/22, revealed, "FOCUS: At risk for altered cardiac /respiratory status. anemia, CAD (coronary artery disease), hyperlipidemia, pulmonary HTN (hypertension), COPD, with acute and chronic respiratory failure with hypoxia, pleural effusion, patent foramen ovale and GERD (gastro-esophageal reflux disease). INTERVENTIONS: 02 as ordered. Monitor for signs/symptoms of decreased cardiac output, rapid, slow, weak or diminished pulse, hypo/hypertension, dizziness, syncope, dyspnea, chest pain, fatigue, restlessness, cyanosis, altered mental status, congestion and shortness of breath. Notify physician as needed with any changes." A review of the physician's orders dated 10/28/22, revealed, "4L (liters per minute) continuous oxygen NC (nasal cannula) - check setting every shift and on rounds everyday shift for O2	F 656		

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Saturation.

A review of the nursing progress note dated 4/22/23 at 8:03 AM, revealed, "Resident was seen lethargic, with an oxygen level of 70% on room air during change of shift. resident was repositioned and 15-liter oxygen was administer via non-rebreather mask. resident O2 went up to 97 % and resident was responsive and having conversation with staff. resident called her full name and was able to identify where she was. O2 level was reduced to 10 liters via non-rebreather mask after resident became stable, alert and oriented X4 and verbally responsive. resident was being monitored every 1 hr. resident retained an oxygen level of 94% to 97% on a simple mask with O2 at 8L per minute. at 0400 (4:00 AM) resident verbalized abdominal pain and was given hydromorphone 2mg which was effective. at this time, writer called hospital on call physician and was awaiting a call back to discuss resident's condition with the physician. but to no avail. at 5 am, resident was stable and resting in bed with an O2 level of 94% via simple mask. At 0540 (5:40 AM), resident was seen unresponsive. there was no pulse or respiration noted. Writer began CPR and another nurse called 911. 911 arrived at about 0559 and began high pressure CPR. Resident could not be resuscitated and was pronounce dead at about 0626 (6:26 AM). Resident is her own responsible party."

An interview was conducted on 6/2/23 at 8:32 AM, with LPN (licensed practical nurse) #3. When asked to describe what changes in condition would necessitate physician notification, LPN #3 stated, not alert, could not arouse, if affect different, talking complete nonsense, oxygen saturation, bleeding, falls. When asked if

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the care plan has intervention of oxygen as ordered and resident is ordered 4 (liters nasal cannula), but oxygen is adjusted to 8-15 liters, is the care plan being followed, LPN #3 stated, "No, not following care plan in that instance."

An interview was conducted on 6/2/23 at 9:00 AM, with RN (registered nurse) #3. RN #3 concurred that if the resident has oxygen orders for 4 liters via nasal cannula, with care plan intervention identified as "oxygen as ordered," and oxygen is adjusted to 8-15 liters, that the care plan was not being followed.

On 6/2/23 at approximately 11:35 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services was made aware of the findings.

No further information was provided prior to exit.
5. a. For Resident #22, the facility staff failed to implement the comprehensive care plan for communication with the dialysis center.

The comprehensive care plan dated, 4/7/2023, documented in part, "Focus: Resident receives dialysis treatments 3 times weekly." The "Interventions" documented in part, "Maintain communication with dialysis staff and physician per routine."

An interview was conducted with R22 on 5/31/2023 at approximately 11:30 a.m. R22 was getting ready to leave for dialysis. The resident had told the CNA (certified nursing assistant) to get the nurse so they could give them the prescription that was still in the front of the communication book. R22 stated that their

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F 656	Continued From page 37 dialysis book was missing for a while, and this is the second book they've had since being admitted to the facility. The dialysis book was reviewed. There was no communication sheet for 5/29/2023. A nurse came and took the prescription from R22. Review of the clinical record failed to evidence documentation of communication with the dialysis center for 16 of 23 days the resident went to dialysis, from 4/5/2023 through 5/31/2023. And the facility staff failed to check the dialysis book after dialysis on 5/29/2023. On 5/31/2023 at 2:46 p.m. the above prescription was reviewed. The prescription dated, 5/29/2023, documented, "Renvela (1) 800 mg (milligrams) 2 tabs (tablets) q (every) 8 hrs (hours) with meals." A request was made of on 6/1/2023, for the missing dialysis communication sheets. On 6/1/2023 at 12:54 p.m. ASM (administrative staff member) #3, the assistant director of nursing, presented dialysis communication sheets dated 4/5/2023 through 5/11/2023. When asked where these documents came from, ASM #3 stated she printed them from the electronic record. When asked if these were the ones sent with the resident for dialysis, ASM #3 stated she had just printed these off today. The forms were blank for where the dialysis center would document on the forms. The resident interview above was shared with ASM #3. An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/2023 at 1:58 p.m. When asked the process for when a resident goes to dialysis, LPN #4 stated the nurse should take the resident's vital signs, document in the	F 656		

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computer on the dialysis communication form, print the form out and send with the resident. LPN #4 was asked the process for when the resident returns from dialysis, LPN #4 stated the nurse should look at the book to see if the dialysis center filled in their section and see if there is any communication from the dialysis center that needs to be initiated or action taken on. When asked if a prescription in the book needs to have action taken on, LPN #4 stated, absolutely. The above observation of the prescription still in the book from 5/29/2023 and still in the book on 5/31/2023, was shared with LPN #4.

On 6/02/2023 at 8:52 a.m., an interview was conducted with LPN #1. LPN #1 stated that the purpose of the care plan was for them to administer patient care and it showed them what they needed to do for the patient and the goals. LPN #1 stated that the care plan was implemented by them doing what it said for them to do on it.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 6/2/2023 at 12:40 p.m.

No further information was provided prior to exit.

4.b For Resident #22 (R22), the facility staff failed to implement the comprehensive care plan for administering treatments per the physician order.

The comprehensive care plan dated, 4/7/2023, documented in part, "Focus: Impaired skin integrity related to: diabetic foot ulcer to left lateral ulcer." The "Interventions" documented in part,

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F 656	Continued From page 39 "Wound treatment per protocol and physician orders." The physician orders dated, 4/17/2023, documented, "Skin Prep Bilateral Heels qs (every shift) and prn (as needed), every shift for skin integrity." The April 2023 MAR (medication administration record) documented the above order. There were blanks, which indicated the treatment was not performed, on the MAR for the day shift on 4/24/2023 and 4/27/2023 and on the evening shift on 4/26/2023. The May 2023 MAR documented the above order. There were blanks on the MAR for the day shift on 5/1/2023, 5/4/2023, 5/6/2023, 5/7/2023, 5/11/2023, 5/20/2023, 5/21/2023, 5/27/2023 and 5/30/2023. There were blanks on the MAR for evening shift on 5/10/2023 and 5/16/2023. There were blanks on the MAR for the night shift on 5/1/2023. An interview was conducted with LPN (licensed practical nurse) #4 on 6/02/2023 at 8:47 a.m. When asked what do the blanks on a TAR mean, LPN #4 stated, "It wasn't done." On 6/02/2023 at 8:52 a.m., an interview was conducted with LPN #1. LPN #1 stated that the purpose of the care plan was for them to administer patient care and it showed them what they needed to do for the patient and the goals. LPN #1 stated that the care plan was implemented by them doing what it said for them to do on it. ASM (administrative staff member) #1, the	F 656		

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F 656	Continued From page 40 administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 6/2/2023 at 12:40 p.m. No further information was provided prior to exit.	F 656		
F 658 SS=G	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, staff interview, clinical record review and facility document review, it was determined the facility staff failed to follow professional standards of quality for two of 34 residents in the survey sample, Resident #18 and Resident #65, which resulted in harm for Resident #65. The findings include: 1. The facility staff, registered nurse (RN #2), failed to ensure oxygen was administered at an acceptable rate for Resident #65, who had a diagnosis of COPD (chronic obstructive pulmonary disease); and, failed to call the physician and/or 911 immediately, when the resident had a significant change in condition. Resident #65 was admitted to the facility on 10/28/22 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), CVA (cerebral vascular	F 658	F 658 1. Address how corrective action was accomplished for the resident(s) affected a. An audit of resident # 18 medications and orders was conducted by DON/designee and all medications were available to be administered as ordered on 6/5/2023. The MD was notified of failing to administer medications to resident per physician's orders and no new orders were received. Resident currently resides in facility with no negative outcomes. b. Resident #65 is no longer in the building.	

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F 658	Continued From page 41 accident), CHF (congestive heart failure), and acute and chronic respiratory failure with hypoxia. A review of the comprehensive care plan dated 10/30/22, included: INTERVENTIONS: 02 (oxygen) as ordered. Monitor for signs/symptoms of decreased cardiac output, rapid, slow, weak or diminished pulse, hypo/hypertension, dizziness, syncope, dyspnea, chest pain, fatigue, restlessness, cyanosis, altered mental status, congestion and shortness of breath. Notify physician as needed with any changes." A review of the physician's orders dated 10/28/22, revealed, "4L (liters) continuous oxygen NC (nasal cannula) - check setting every shift and on rounds every day shift for O2 (oxygen) Saturation." A review of the facility's "Standing Orders" revealed, "Shortness of breath (SOB)/difficulty breathing: may place oxygen at 2 liters/minute via nasal cannula as needed for SOB or saturation below 89%. If oxygen saturation less than 87% with difficulty breathing, obtain stat chest x-ray and call physician STAT (immediately). Transfer: In case of an emergency when attending physician is unable to be reached, you may transfer to hospital." A review of the nursing progress note written by RN #2, dated 4/22/23 at 8:03 AM included, "Note Text: Resident was seen lethargy, with an oxygen level of 70% at room air during change of shift. resident was repositioned and 15 liter oxygen was administer via non-rebreather mask. resident O@ [sic] went up to 97 % and resident was responsive and having conversion with staff. resident called her full name and was able to	F 658	2. Address how the facility will identify other residents with potential to be affected. All residents who have had a significant change have the potential to be affected. DON/ designee conducted a quality review of records for residents with changes in condition in the past 72 hours as of 6/6/23. DON/ designee educated nurses where discrepancies were noted. All residents who currently reside in the facility with discrepancies were discussed with the provider with no negative outcomes noted. b. All residents have the potential to be affected by this deficiency. On 6/9/2023 a report of all medications documented not given due to unavailability was reviewed by DON/ designee for the last 7 days. Any negative findings were followed-up with provider notification. No further orders were given.	

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F 658	Continued From page 42 identify where she was. O2 level was reduced to 10 liter via non-rebreather mask after resident became stable, alert and oriented X4 and verbally responsive. resident was being monitored every 1 hr. resident retained an oxygen level of 94 to 97% on a simple mask with o2 at 8Lmp. at 0400 resident verbalized abdominal pain and was given hydromorphone 2mg which was effective. at this time, writer called (physician hospital group) on-called [sic] and was awaiting a call back to discuss resident's condition with the DR. (doctor) but to no avail. at 5 am, resident was stable and resting in bed with an O2 level of 94% via simple mask. at 0540, resident was seen unresponsive. there was no pulse or respiration noted. Writer began CPR and another nurse called 911. 911 arrived at about 0559 and began high pressure CPR. resident could not be resuscitated and was pronounce [sic] dead at about 0626. Resident is he [sic] own responsible party..." An interview was conducted on 6/3/23 at 8:30 AM with LPN (licensed practical nurse) #3. When asked the amount of oxygen that should be given to a resident with COPD, LPN #3 stated, "We would follow the orders, but I would not ever go past 5 liters per minute." An interview was conducted on 6/3/23 at 9:10 AM with ASM (administrative staff member) #4, the nurse practitioner (NP). When asked when should the NP be notified for oxygen saturation, ASM #4 stated, "We should have been notified for anything less than 87% per the standing orders." When asked what are the maximum oxygen liters per minute for a COPD resident, ASM #4 stated, "It is 4-5 liters per minute." An interview was conducted on 6/2/23 at 9:49 AM	F 658	3. Address measures to be put in place to ensure deficient practice does not recur. a. In-service was conducted by the DON/ designee to the licensed nursing staff on the requirement that all medications are to be provided as ordered. Education was completed on 6/12/2023. Staff will not be allowed to return to work until they received this education. All new hires involved in this process will receive this education in orientation process starting 6/13/2023. b. DON/ designee will educate licensed nurses on requirements to notify MD of significant change in conditions to include oxygen saturations and needing an MD order to change. Education was completed on 6/12/2023. Staff will not be allowed to return to work until they received this education. Education will be included in new hire orientation as well as agency orientation effective 6/13/2023.	

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F 658	Continued From page 43 with RN (registered nurse) #2, who was the nurse on duty at the time of the event. When asked to describe the events of 4/21/23-4/22/23 with Resident #65, RN #2 stated, "I got there late, between 11:30 PM-12:00 AM on 4/21/23. I made my rounds and the resident was laying across the bed. Her oxygen (O2) was not on. She was lethargic. Her vital signs were normal and O2 saturation was low about 77-78%. I increased her to 15 LNC (liters nasal cannula), got her situated and her O2 saturation came up to 92-93%. Then she was alert and oriented." RN #2 stated, "I kept monitoring her oxygen and trying to decrease it. I could not get it back to 4 LNC because her saturation would drop. I had her on a rebreather and finally got her down to 8 liters. I told her that I have to send her to the hospital. She did not want to go. She started having stomach pain, so I gave her narcotic for the pain." RN #2 stated, "At 4:00 AM, I called the hospital doctor exchange. I did not get a call back. I called the DON (director of nursing) to let her know of the situation. Resident was reassessed with O2 saturation in 90's on the 8 L face mask. About 5:00 AM, I called the hospital doctor exchange again, talked to resident, and said I have to send you out but the Resident refused to go." RN #2 added, "I was the only nurse on the unit, with one CNA...around 5:40 AM, I went to check on (Resident #65) and she was unresponsive. I put her on the floor and started CPR (cardiopulmonary resuscitation)." When asked if there were orders to adjust the oxygen, RN #2 stated, "No, there was no order. We have standing orders, but they do not cover higher oxygen. I could not keep her on that low oxygen rate. That's the reason I called the physician exchange and the DON. The resident was stable on the higher oxygen, she was not	F 658	4. Indicate how facility will monitor performance to ensure solutions are sustained. a. The DON/ designee will review the 24 hour report for missing medications in morning meeting x 12 weeks starting 6/19/2023. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. b. DON/ designee will audit resident records/incident notes for changes in condition to include oxygen saturations and flow to ensure MD notification was completed during morning meeting x12 weeks starting 6/19/2023. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed 6/21/23	

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F 658	Continued From page 44 critical at the time, so I did not call 911. I did my due diligence and got her oxygen saturation back up by increasing her oxygen level." There was not documentation in the clinical record that the director of nursing was called at 4:00 AM as stated in the interview with RN #2, nor was there was no documentation of the second attempt to reach the on-call physician nor did RN #2 call the facility medical director. There was no documentation in the clinical record that RN #2 told Resident #65 that she'd have to be sent out to the hospital, nor that the resident refused to go. An interview was conducted on 6/2/23 at 11:10 AM with ASM #7, the medical director who concurred that the physician should be notified for an O2 saturation of 70%. When asked what the maximum oxygen rate for a resident with COPD, and acute and chronic respiratory failure with hypoxia should be set at, ASM #7 stated, "The maximum is oxygen 4-5 liters per minute." On 6/2/23 at approximately 11:35 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services was made aware of the findings. A review of the facility's "Oxygen Administration (all routes)" policy dated 11/2019, reveals, "Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider. In an emergency situation, clinicians may administer oxygen and obtain a provider's order as soon as practicably possible after patient stabilization or transfer."	F 658		

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F 658	Continued From page 45 Lippincott Nursing Standards of Practice 11th Edition, page 180, revealed, "Administer oxygen in the appropriate concentration and device. Low concentration (24-28%) may be appropriate for patients prone to retain CO2 (carbon dioxide) [COPD, drug overdose] who are dependent on hypoxemia (hypoxic drive) to maintain respiration. If hypoxemia is suddenly reversed, hypoxic drive may be lost and respiratory depression and, possibly respiratory arrest may occur." No further information was provided prior to exit. 2. For Resident #18 (R18), the facility staff failed to administer a medication that was available in the in-house medication supply on 4/21/2023 at 9:00 a.m. and 1:00 p.m. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/1/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) indicating they were cognitively intact for making daily decisions. On 5/31/2023 at 12:07 p.m., an interview was conducted with R18 in their room. R18 stated that the nurse's frequently ran out of their medications. R18 stated that they kept track of the medications that they took and how many so they noticed if there was less than the normal amount in the cup when they brought it in the room and questioned the nurses. R18 stated that it happened with multiple medications including their Parkinson's medications, vitamins, supplements and heartburn medication. R18 stated that the nurses told them that they were out of the medication or they could not find it.	F 658		

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F 658	Continued From page 46 A review of R18's clinical record revealed the following physician's orders: - "Carbidopa-Levodopa (1) Tablet 25-100 MG Give 2 tablet by mouth three times a day for Parkinson's disease. Order Date: 02/07/2023." A review of R18's April 2023 eMAR failed to reveal evidence that Carbidopa-Levodopa tablet 25-100 mg was administered on 4/21/2023 at 9:00 a.m. and 1:00 p.m. A review of the eMAR note dated 4/21/2023 08:08 (8:08 a.m.) and 15:36 (3:36 p.m.) documented, "Med on order will administer once arrived." On 6/1/2023 at 11:35 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a resident's medication was not available they checked the extra storage on the medication cart and medication room. LPN #1 stated that if the medication was not available in house they contacted the pharmacy to deliver the medication stat. LPN #1 stated that if they were unable to get the medication delivered stat, they contacted the physician for an alternate order or hold order. LPN #1 stated that they had an automated dispensing system for a variety of stock medications in their medication room and it had been in place since they had begun working there in April. LPN #1 stated that all nurses had access to the automated medication dispensing system that they knew of and they could pull medications from it for stat medications and for medications that were not on the cart for residents when on order from the pharmacy. LPN #1 stated that if the resident was out of the medication the nurse should call the physician to notify them that the dosage was missed and document in the eMAR notes.	F 658		

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F 658	Continued From page 47 The facility policy "Medication Shortages/Unavailable Medications" with a revision date of 1/1/2022 documented in part, "...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take action to notify the Pharmacy...If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose..." On 6/1/2023 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were made aware of the above concern. Reference: (1) The combination of levodopa and carbidopa is used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms that may develop after encephalitis (swelling of the brain) or injury to the nervous system caused by carbon monoxide poisoning or manganese poisoning. Parkinson's symptoms, including tremors (shaking), stiffness, and slowness of movement, are caused by a lack of dopamine, a natural substance usually found in the brain. Levodopa is in a class of medications called central nervous system agents. It works by being converted to dopamine in the brain. Carbidopa is in a class of medications called decarboxylase inhibitors. It works by preventing levodopa from being broken down before it reaches the brain. This allows for a	F 658		

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F 658	Continued From page 48 lower dose of levodopa, which causes less nausea and vomiting. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601068.html	F 658	F -676 1. Address how corrective action was accomplished for the resident(s) affected. Resident # 56 was provided a communication board to ensure care plan is correct on 6/9/23. Resident #56 remains in the facility with no obvious negative impact. 2. Address how the facility will identify other residents with potential to be affected. All residents who require a communication board have the potential to be affected. On 6/8/2023 the DON/ designee assessed all residents to ensure any needs for communication devices are being met. All discrepancies were corrected at that time.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities 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	F 676		

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F 676	Continued From page 49 snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to promote a residents ability to communicate independently for one of 34 residents, Resident #56. The findings include: The facility staff failed to provide services to promote independent communication with facility staff for Resident #56 (R56), whose primary language spoken was Hungarian. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/13/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. Section B documented R56 having moderate difficulty with hearing and wearing hearing aids. It also documented R56 having impaired vision, wearing corrective lenses and able to see large print but not regular print. Section F documented having books, newspapers and magazines to read and participating in religious services or practices somewhat important to them. It documented a resident representative completing the assessment for the resident.	F 676	3. Address measures to be put in place to ensure deficient practice does not recur. The DON/ designee educated licensed nurses, therapists, and social workers on the requirements for communication services to include following care plan interventions. Education was completed on 6/8/2023. Staff will not be allowed to return to work until they received this education. Any new hires involved in this process will receive this education in orientation process starting 6/9/2023.	

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F 676	Continued From page 50 On 5/31/2023 at 1:02 p.m., R56 was observed sitting in a wheelchair in their room listening to the radio. At that time an interview was attempted with R56. R56 stated, "No English." R56 proceeded to pick up their cell phone and attempted to make a call with no answer. No communication tools were observed in R56's room. On 5/31/2023 at 2:28 p.m., an interview was conducted with R56's granddaughter who was visiting in the room. When asked how the staff communicated with R56, she stated that they were unsure. R56's granddaughter stated that R56 knew a few words, could point to things and staff would call them as needed. R56's granddaughter stated that they were not aware of any type of communication tools that the facility staff used. The comprehensive care plan for R56 documented in part, "Inability to express emotion, listen and share information. Alteration in communication related to: hearing deficit, Language barrier, blindness. Date Initiated: 03/08/2023. Created on: 02/15/2023." Under "Interventions" it documented in part, "...Teach resident how to use communication book/ board/ electronic device. Date Initiated: 03/08/2023. Created on: 02/15/2023..." The care plan further documented, "Resident has a variety of leisure interests but prefers to participate in self-directed leisure. Date Initiated: 03/08/2023. Created on: 02/15/2023." Under "Interventions" it documented in part, "Resident will be given leisure supplies in Hungarian due to language barrier. Date Initiated: 03/08/2023. Created on: 02/15/2023..."	F 676	4. Indicate how facility will monitor performance to ensure solutions are sustained. DON/ designee will audit records and round on residents requiring a communication board weekly to ensure proper placement. All newly admitted residents will be assessed for the need for communication devices in the morning meeting for 12 weeks starting 6/19/23. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 676	Continued From page 51 The progress notes for R56 documented in part, - "2/15/2023 19:31 (7:31 p.m.) Note Text : IDT (interdisciplinary) team notified by family member of resident's hard of hearing, blindness and language barrier. Resident speaks Hungarian. Assistive devices in use: Resident's has hearing aides. Communication board offered to resident- resident's son requests that facility calls him for interpretation. Son visits everyday- requests that son's number is placed by bedside wall." - "2/26/2023 10:55 (10:55 a.m.) Nursing note...residents' primary language is not English, daughter was able to help resident communicate needs during shift..." - "3/19/2023 12:22 (12:22 p.m.) Nursing note...Resident is alert and oriented x 4 (person, place, time and situation) but does have difficulty expressing needs due to language barrier. Resident uses body language many times to express needs, which is effective..." - "3/23/2023 22:58 (10:58 p.m.) Nursing note...Resident is alert and oriented x 3 (to person, place and time), with language barrier. Resident's primary language is Hungarian. Resident is able to say a few words in English to communicate needs, and uses body language to communicate. Resident's family does provide assistance with translating..." - "4/4/2023 18:13 (6:13 p.m.) Nursing note...Some language barriers, but able to make needs known to staff..." - "4/6/2023 13:41 (1:41 p.m.) This writer observed that resident began to cry and became very emotional after son stated resident will remain LTC (long term care) due to the increased amount of assistance with ADLs (activities of daily living). Resident stated in native language that she feels lonely and does not have companionship due to language barrier. Son has	F 676		

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been coming in to visit resident every day and is communication with nursing staff/SW (social worker). Son has advised to always call him for translation. SS (social services) will assist in finding LCAs, organizations/groups that speak Hungarian/Romanian for resident companionship. Resident and resident's son agrees."

On 6/1/2023 at 11:35 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that there was a language barrier with R56. LPN #1 stated that R56 did not speak fluent English and would point to things or use hand gestures to communicate with staff. LPN #1 stated that they called the resident's son for any communication with the resident. LPN #1 stated that they were not aware of any type of communication board. LPN #1 stated that they pointed to things to communicate with R56 or called the son as needed to communicate with them.

On 6/2/2023 at 8:48 a.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that R56 used hand gestures, nodded their head and gives them the thumbs up to communicate. CNA #4 stated that R56 understood limited English and could point to the juice, coffee and water to make decisions. CNA #4 stated R56 did not have a communication board because they could speak but could not speak English.

On 6/2/2023 at 8:58 a.m., an interview was conducted with OSM (other staff member) #8, life enrichment. OSM #8 stated that they worked with R56 and provided activities like doing their nails and taking them outside. OSM #8 stated that they had attempted to get them to participate

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in group activities but they had refused by shaking their head "no." OSM #8 stated that they had taken their communication board when they went to visit with R56 but they did not leave it in the room. OSM #8 stated that they had not provided any books or magazines for R56 in Hungarian but that it was a good idea. OSM #8 stated that they thought that perhaps social services was working on setting up a personalized communication board for R56.

On 6/2/2023 at 9:05 a.m., an interview was conducted with OSM # 6, the director of social services. OSM #6 stated that they had requested R56's son to set up a communication board and the director of rehab was working with them. OSM #6 stated that they had discussed this about a month ago. OSM #6 stated that they had reached out to a few organizations and were still trying to find churches in the area that may offer volunteers to come to the facility for R56.

On 6/2/2023 at 9:17 a.m., an interview was conducted with OSM #5, the director of rehab services. OSM #5 stated that they were not technically working on setting up a communication board for R56. OSM #5 stated that they had spoken to R56's son who stated that they would work with activities to facilitate a communication board. OSM #5 stated that they were told by the former activities director that R56's son did not comply with setting up the communication board. OSM #5 stated that it should be the facilities responsibility to facilitate communication with the resident not the family.

On 6/2/2023 at approximately 9:30 a.m., a request was made to ASM (administrative staff member) #3, assistant director of nursing, for

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F 676	Continued From page 54 evidence of facility interventions regarding the language barrier with R56. On 6/2/2023 at approximately 10:10 a.m., ASM #2, the director of nursing provided the progress note dated 2/15/2023 documented above. On 6/2/2023 at approximately 11:00 a.m., a follow up interview was conducted with OSM # 6, the director of social services. When asked about the progress note provided dated 2/15/2023, OSM #8 stated that R56's son had declined the communication board that they offered on 2/15/23. OSM #6 stated that R56's son did not really state why he declined the communication board other than it would not work. OSM #6 provided the communication board from their desk, a laminated page approximately 8.5 x 11 inches in size with large pictures of ADL tasks with the English words written underneath. OSM #6 stated that R56 was blind and hard of hearing. When asked if R56 was legally blind and could feed themselves, OSM #6 stated, "Yes." When asked if R56 would be able to see a communication board, OSM #6 stated, "Yes." OSM #6 stated that this conversation was with R56's son when R56 was at the facility for short-term rehabilitation and they had not had any conversations or approached the subject with the son or the resident since the decision had been made to stay at the facility long term. OSM #6 stated that they had not had a care plan meeting since the transition to long term care but it was scheduled this month. The facility policy, "Communication with Persons with Limited English Proficiency" with a revision date of 4/15/2021 documented in part, "[Name of facility] will take reasonable steps to ensure that	F 676		

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F 676	Continued From page 55 persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits..." On 6/2/2023 at 12:42 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 34 residents in the survey sample, received the care and services in accordance with professional standards and the comprehensive care plan for Resident #22. The findings include: For Resident #22 (R22), the facility staff failed to administer a treatment to the resident's feet per the physician order.	F 684	F – 684 1. Address how corrective action was accomplished for the resident(s) affected The MD was notified of failing to administer a treatment to resident #22 per physician's orders on 5/31/23 and no new orders at that time. The treatment was discontinued due to heels having no redness on 6/14/23. Resident continues to reside in the facility with no negative outcomes.	

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F 684	Continued From page 56 On the most recent, MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/25/2033, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. An interview was conducted with R22 on 5/31/2023 at approximately 11:30 a.m. R22 stated the nurses are not doing her treatments to her feet as ordered. The physician orders dated, 4/17/2023, documented, "Skin Prep Bilateral Heels qs (every shift) and prn (as needed), every shift for skin integrity." The April 2023 MAR (medication administration record) documented the above order. There were blanks (areas where staff would document were left blank) on the MAR for the day shift on 4/24/2023 and 4/27/2023 and on the evening shift on 4/26/2023. The May 2023 MAR documented the above order. There were blanks on the MAR for the day shift on 5/1/2023, 5/4/2023, 5/6/2023, 5/7/2023, 5/11/2023, 5/20/2023, 5/21/2023, 5/27/2023 and 5/30/2023. There were blanks on the MAR for evening shift on 5/10/2023 and 5/16/2023. There were blanks on the MAR for the night shift on 5/1/2023. The comprehensive care plan dated, 4/7/2023, documented in part, "Focus: Impaired skin integrity related to: diabetic foot ulcer to left lateral ulcer." The "Interventions" documented in part,	F 684	2. Address how the facility will identify other residents with potential to be affected. All residents have the potential to be affected by this deficiency. On 6/15/2023 a report of all treatment omission was reviewed by DON/ designee for the last 14 days to ensure no treatments were omitted. Any negative findings were followed-up with provider notification. No further orders were given. 3. Address measures to be put in place to ensure deficient practice does not recur. In-service will be conducted by the DON/designee to the licensed nursing staff on the requirement that all treatments are to be provided as ordered. Education will be completed on 6/20/2023. Staff will not be allowed to return to work until they received this education. Any new hires involved in this process will receive this education in orientation process starting 6/21/2023.	

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F 684	Continued From page 57 "Wound treatment per protocol and physician orders." An interview was conducted with LPN (licensed practical nurse) #4 on 6/02/2023 at 8:47 a.m. When asked what do the blanks on a TAR mean, LPN #4 stated, "It [the treatment] wasn't done." The facility provided a policy, "Physician/Provider Orders" did not address the administration of treatments as ordered. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 6/2/2023 at 12:40 p.m. No further information was provided prior to exit.	F 684	4. Indicate how facility will monitor performance to ensure solutions are sustained. The DON/ designee will review the 24 hour report for missing treatments in morning meeting x 12 weeks starting 6/19/2023. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices 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 that the facility staff failed to provide the proper assistance while providing ADL (activities of daily living) care which resulted in a fall from the bed for one of 34 residents in the survey sample,	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 58 Resident #219. The resident sustained a right leg fracture which constituted harm cited at past non-compliance. The findings include: For Resident #219 (R219), the facility staff failed to implement the plan of care while providing ADL care which resulted in the resident falling from the bed and suffering a fractured right tibia and fibula (1). R219 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (2) and osteoarthritis (3). On the residents MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/10/2022, the resident scored 9 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired for making daily decisions. Section G documented R219 being totally dependent on two persons for transfers and requiring extensive assistance of two persons for bed mobility. The assessment further documented R219 being frequently incontinent of bowel and bladder and having two falls without injury since the previous assessment. The progress notes for R219 documented in part; "11/09/2022 13:12 (1:12 p.m.) Monthly Nursing Note...Two+ persons physical assist with transfers. Two+ persons physical assist with bed mobility. One person physical assist with eating. Resident is a two+ persons physical assist with toilet use..." "11/13/2022 07:15 (7:15 a.m.) Type: Head to Toe Eval. (evaluation) Overview: This note is a follow	F 689		

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F 689	Continued From page 59 up to witnessed fall. Resident is Oriented to room location. Resident knows staff names/faces. Resident is responsive. Resident is Anxious. Resident in pain and crying out. Neurological checks are within normal limits. Evidence of pain noted R (right) hip and leg. Non- verbal signs of pain noted. Pain level is 10 out of 10. The pain is constant...Family notified of incident and is aware resident was sent to the ER (emergency room) via EMS (emergency medical services)." The physician orders for R219 documented in part, "Send Resident to ER for evaluation and treatment s/p (status post) fall. Order Date: 11/13/2022." The comprehensive care plan for R219 documented in part, - "Risk for falls characterized by history of falls, injury, and/or multiple risk factors related to: Intractable seizures, osteoarthritis, dementia. Actual fall: 11/13/22. Date Initiated: 08/05/2022." Under "Interventions" it documented in part, "10/24/22: bed in lowest position when in bed. Pain medication review. Date Initiated: 10/24/2022..." - "At risk for self care deficit r/t (related to) dementia, seizures, risk for malnutrition, muscle weakness, abnormalities of gait and mobility. Date Initiated: 08/05/2022." Under "Interventions" it documented in part, "...Encourage turning and repositioning, assist as needed. Date Initiated: 08/05/2022..." - "Alteration in musculoskeletal status r/t right tibial and fibula fracture. Date Initiated: 11/14/2022." The fall risk assessment for R219 dated 11/8/2022 documented the resident being a high	F 689		

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F 689	Continued From page 60 risk for falls. On 5/31/2023 at 5:23 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for the synopsis of fall event which occured on 11/13/2022 for R219. On 6/1/2023 at approximately 8:00 a.m., ASM #1 provided a folder containing a plan of correction for the fall on 11/13/2022 for R219. The document contained a "Quick Response" dated 11/13/2022 which documented in part, "...Resident with witnessed fall out of bed onto her right side on top of her fall mat. Send to ER for evaluation due to right leg pain, X-rays at hospital show right tibia and fibula fracture. Resident unable to give description..." The "Witnessed Fall document" dated 11/13/2022 documented in part, "This nurse was alerted that the resident had a witnessed fall. The resident's CNA (certified nursing assistant) was repositioning the resident to her side to change her brief. The aide reports that the resident rolled off the bed. The aide reports that the bed was in a low setting. Bed was in lowest setting when this writer entered the resident's room. Resident was lying on her back on a fall mat to the R (right) of her bed. The aide reported that resident fell onto her R side. Resident unable to give description..." On 6/1/2023 at 9:42 a.m., an attempt was made to contact CNA #6 who took care of R219 at the time that they rolled out of bed. The phone number was no longer in service. On 6/1/2023 at 10:26 a.m., an interview was conducted with LPN #3 who worked with R219 on 11/13/2022 on the date of the fall. LPN #3 stated	F 689		

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F 689	Continued From page 61 that they were called into R219's room on 11/13/2022 after the resident had rolled out of the bed, when the CNA was providing care. R219 was observed on the floor on the fall mat and was yelling out in pain. The bed was raised to the CNA's waist level. The CNA stated that they were changing the resident and the resident had slipped off of the bed, and the CNA was the only staff person in the room at the time of the fall. LPN #3 stated that they had assessed the resident, checked the vital signs, and then transferred the resident back to the bed which was lowered before they put the resident back in bed with the draw sheet. LPN #3 stated that they should have used a hoyer lift to transfer the resident back to the bed and knew that now. LPN #3 stated that after they got the resident back in the bed they had called the former director of nursing, physician and the family. R219 did not speak English very well and they had spoken with the family member who advised them that the resident did not want to go to the hospital but advised them that they felt that the resident needed to be sent out due to the amount of pain they were having in the leg. LPN #3 stated that the family member was able to convince the resident to go to the emergency room and the resident was sent out. On 6/01/2023 at 1:10 p.m., an interview was conducted with CNA #1. CNA #1 stated that they determined the assistance level of residents from the resident if they were able to tell them or from the previous CNA in walking report. CNA #1 stated that they also had a care plan that they reviewed in the computer which showed the assistance levels for residents. CNA #1 stated that they worked with the other aides for residents who required two person assistance and the	F 689		

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F 689	Continued From page 62	F 689		

nurses would help them if the aides were unavailable. CNA #1 stated that they would not attempt to provide care alone for a resident if two persons were needed.

On 6/01/2023 at 1:20 p.m., an interview was conducted with CNA #3. CNA #3 stated that they determined the assistance level of residents from the report from the previous CNA, from therapy, or the Kardex on the computer. CNA #3 stated that when the resident required two persons for bed mobility they asked the other CNA's to assist them and would never attempt the care alone due to safety.

Review of the plan of correction provided by ASM #1 for R219's fall on 11/13/2022 documented a date of compliance of 11/30/2022. The plan of correction folder contained written staff statements from LPN #3 and CNA #6 and an investigation completed by the former director of nursing who no longer worked at the facility. The plan of correction documented audits conducted of current residents bed mobility, care plans and Kardexs, education provided to staff, including the aide involved in the event on falls and positioning, including bed mobility, turning and positioning and assisting a resident after a fall. The plan of correction folder further documented resident audits completed for the appropriate level of care assistance based on their Kardex and care plan. Verification of the facility plan of correction was completed by observations, staff interviews and review of the facility audits, staff education and resident audits. No concerns were identified.

On 6/1/2023 at 1:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing

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F 689	Continued From page 63 were made aware of the concern for harm. No further information was provided prior to exit. Based on the acceptable plan of correction, all components of the plan verified, and no concerns identified during the survey, this deficient practice is cited at past non-compliance. Reference: (1) The lower leg is made up of two bones: the tibia and fibula. The tibia is the larger of the two bones. It supports most of your weight and is an important part of both the knee joint and ankle joint. The tibia is the larger bone in your lower leg. Tibial shaft fractures occur along the length of the bone. This information was obtained from the website: https://orthoinfo.aaos.org/en/diseases--conditions/tibia-shinbone-shaft-fractures/ (2) Osteomyelitis is a bone infection. It is mainly caused by bacteria or other germs. This information was obtained from the website: https://medlineplus.gov/ency/article/000437.htm (3) Osteoarthritis, sometimes called OA, is a type of arthritis that only affects the joints, usually in the hands, knees, hips, neck, and lower back. It's the most common type of arthritis. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		

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F 695	Continued From page 64 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice for two of 34 residents, Resident #59 and Resident #122. The findings include: 1. For Resident #59 (R59), the facility staff failed to administer oxygen at the prescribed rate. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/20/2023, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section O documented R59 receiving oxygen at the facility. On 5/31/2023 at 12:56 p.m., R59 was observed in bed wearing an oxygen cannula. The oxygen tubing was dated 5/22 and was set at a rate of 2.5 lpm (liters per minute). Additional observations were made of R59 on 5/31/2023 at 4:10 p.m. and 6/1/2023 at 8:48 a.m. wearing the oxygen cannula with the rate at 2.5 lpm.	F 695	F – 695 1. Address how corrective action was accomplished for the resident(s) affected. Resident #59s oxygen flowrate was adjusted to reflect physicians order upon discovery on 6/1/23 during the survey. Resident #122 nebulizer mask was placed in a bag upon discovery on 6/1/23 during the survey. Both residents reside in the facility with no negative outcomes. 2. Address how the facility will identify other residents with potential to be affected. Any resident requiring oxygen treatments has the potential to be affected. DON/ designee conduced an audit of residents requiring oxygen and nebulizers on 6/6/2023 to verify oxygen is at prescribed flowrate and nebulizer masks are stored correctly. No other areas of concern were identified.	

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F 695	Continued From page 65 The physician orders for R59 documented in part, "Oxygen: via NC (nasal cannula) at 3L (liters) to maintain SPO2>90% (oxygen saturation greater than 90%), SPO2 check Q (every) shift, every shift. Order Date: 05/31/2023." The comprehensive care plan for R59 documented in part, "At risk for altered cardiac/resp (respiratory) status related to aortic stenosis, CAD (coronary artery disease), "white coat syndrome." Date Initiated: 03/31/2023. Revision on: 04/05/2023..." Under "Interventions" it documented in part, "O2 (oxygen) as ordered..." On 6/1/2023 at 11:35 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that oxygen was checked every day and administered at the rate based on the order. LPN #1 stated that the flowmeter ball should be centered on the line for the number of the ordered rate. LPN #1 stated that when they checked the rate of the oxygen they read it at eye level. LPN #1 observed R59's oxygen and stated that it was set at 2 lpm. LPN #1 reviewed the order for R59's oxygen and stated that it was ordered at 3 lpm and someone must have set it wrong. The facility policy, "Oxygen Administration" with a revision date of 12/16/2019 documented in part, "...For oxygen concentrator, plug in power cord, turn unit on and set flow meter to correct flow rate..." The facility provided manufacturers users manual for R59's oxygen concentrator documented in part, "...Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the	F 695	3. Address measures to be put in place to ensure deficient practice does not recur. The DON/ designee will educate licensed nurses on their responsibility for following medical provider orders for prescribed oxygen flowrate and how to properly store unused respiratory equipment including nebulizer masks. Education was completed on 6/8/2023. Staff will not be allowed to return to work until they received this education. Any new hires involved in this process will receive this education in orientation process starting 6/9/2023.	

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F 695	Continued From page 66 specific flow rate..." On 6/1/2023 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 2. For Resident #122 (R122), the facility staff failed to store a nebulizer mouthpiece in a sanitary manner. On 5/31/2023 at approximately 11:45 a.m. R122 room was observed. There was a nebulizer machine on the nightstand. The mouthpiece used for the administration of medication was open to air. Further observations were made on 5/31/2023 at 2:55 a.m. and 6/1/2023 at 8:12 a.m. and the mouth piece was exposed to air, not covered. On 6/1/2023 at 12:42 p.m. the nebulizer mouthpiece was observed to be exposed to air again and this observation was shared with LPN (licensed practical nurse) #5 at the time. When asked how a nebulizer mouthpiece should be stored when not in use, LPN #5 stated, "It should be rinsed after use and stored in a plastic bag." The physician order dated, 5/21/2023, documented, "Ipratropium-Albuterol Solution [1] 0.5 - 3.5 (3) MG/3ML (milligrams per 3 milliliter), 3 ml inhale orally every 6 hours related to Chronic Obstructive Pulmonary Disease." The MAR (medication administration record) for May 2023 documented the above order. It was documented that the medication had been	F 695	4. Indicate how facility will monitor performance to ensure solutions are sustained. The DON/ designee will round on residents receiving respiratory services weekly x 12 weeks starting 6/19/23 to verify oxygen flowrate is at prescribed rate and unused respiratory equipment such as nebulizer masks are stored appropriately. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 695	Continued From page 67 administered on 5/31/2023 at 12:00 a.m., 6:00 a.m., and 6:00 p.m. The June 2023 MAR documented the above order. It was documented the resident refused their treatments on 6/1/2023 at 12:00 a.m., 6:00 a.m. and 12:00 p.m. doses of the medication. The facility policy, "Nebulizer Administration Policy" documented in part, "15. Empty nebulizer cup, rinse with sterile water/sterile saline and air dry. Wipe mask with alcohol wipe and store the neb set in a plastic bag labeled with the patient's name when dried." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m. No further information was provided prior to exit. [1] Ipratropium-Albuterol Solution is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601063.html.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEREA HEALTH & REHAB CENTER	55 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

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F 698	Continued From page 68 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain ongoing communication with the dialysis center for two of 34 residents in the survey sample, Residents #22 and #35. The findings include: 1. For Resident #22 (R22) the facility staff failed to evidence communication with the dialysis center for 16 of 23 days the resident went to dialysis, from 4/5/2023 through 5/31/2023. And, the facility staff failed to check the dialysis book after dialysis on 5/29/2023. On the most recent, MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/25/2033, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis while a resident at the facility. An interview was conducted with R22 on 5/31/2023 at approximately 11:30 a.m. as R22 was getting ready to leave for dialysis. The resident had told the CNA (certified nursing assistant) to get the nurse so they could give them the prescription that was still in the front of the communication book. R22 stated that their dialysis book was missing for "a while," and this is the second book they've had since being admitted to the facility. The dialysis book was	F 698	F -698 1. Address how corrective action was accomplished for the resident(s) affected. 30 days of visit summaries from dialysis center were obtained for resident #35 and #22 and scanned into their electronic medical record (EMR). Summaries were reviewed and any new orders were processed for both residents. Both residents reside in the facility and have no negative outcomes. 2. Address how the facility will identify other residents with potential to be affected. Any resident receiving dialysis services has the potential to be affected. On 6/7/2023 a review current residents was completed by DON/designee and no other residents are currently residing in the facility who receive dialysis services.	

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F 698	Continued From page 69 reviewed. There was no communication sheet for 5/29/2023. A nurse came and took the prescription from R22. On 5/31/2023 at 2:46 p.m. the above prescription was reviewed. The prescription dated, 5/29/2023, documented, "Renvela (1) 800 mg (milligrams) 2 tabs (tablets) q (every) 8 hrs (hours) with meals." A request was made on 6/1/2023, for the missing dialysis communication sheets. On 6/1/2023 at 12:54 p.m. ASM (administrative staff member) #3, the assistant director of nursing, presented dialysis communication sheets dated 4/5/2023 through 5/11/2023. When asked where these documents came from, ASM #3 stated she printed them from the electronic record. When asked if these were the ones sent with the resident for dialysis, ASM #3 stated she had just printed these off today. The forms were blank where the dialysis center would document on the forms. The resident interview above was shared with ASM #3. The comprehensive care plan dated, 4/7/2023, documented in part, "Focus: Resident receives dialysis treatments 3 times weekly." The "Interventions" documented in part, "Maintain communication with dialysis staff and physician per routine." An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/2023 at 1:58 p.m. When asked for the process when a resident goes to dialysis, LPN #4 stated the nurse should take the resident's vital signs, document in the computer on the dialysis communication form, print the form out and send with the resident. LPN #4 was asked the process for when the resident	F 698	3. Address measures to be put in place to ensure deficient practice does not recur. The DON/ designee educated licensed nurses on their responsibility to communicate with the dialysis provider including review of post dialysis services for any new orders. Education was completed on 6/8/2023. Staff will not be allowed to return to work until they received this education. Any new hires involved in this process will receive this education in orientation process starting 6/12/2023. 4. Indicate how facility will monitor performance to ensure solutions are sustained. The DON/ designee will audit all residents receiving dialysis services weekly x12 weeks starting 6/19/23 to verify communication to dialysis provider including review of any new orders. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 698	Continued From page 70 returns from dialysis, LPN #4 stated the nurse should look at the book to see if the dialysis center filled in their section and see if there is any communication from the dialysis center that needs to be initiated or action taken on. When asked if a prescription in the book needs to have action taken on, LPN #4 stated, absolutely. The observation of the prescription that was still in the book from 5/29/2023 and still in the book on 5/31/2023, was shared with LPN #4. The facility policy, "Hemodialysis Care Policy" documented in part, "Pre-dialysis process: Administer/hold medications as ordered by provider. Assess resident's condition and communicate any concerns to dialysis provider. If the resident's stability to go to dialysis is in question, notify the dialysis provider for discussion and/or assessment to ascertain if treatment is advisable. If treatment is deferred, the primary provider will be notified for any further orders. Document assessment in the Dialysis Communication Tool. Assessment includes: Vital signs, Pre-treatment weight (unless performed at dialysis), Medications administered before treatment, Time of last meal, Fluid intake, Any additional alerts or information, Print the Tool and send with resident to dialysis (if off-site), Arrange for packed meal to be sent with resident if they will be gone over a mealtime...Post-dialysis process: Receive report from dialysis provider and/or review Dialysis Communication Tool documentation by dialysis provider. Contact dialysis provider promptly with any questions or concerns. Information post-dialysis will include: Amount of fluid removed, Vital signs, Post-treatment weight (unless to be completed by SNF), Lab draws and/or results, Medications administered during or after treatment, Any new	F 698		

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F 698	Continued From page 71 orders, Any additional alerts or information, Monitor fistula/graft/catheter site for bleeding, Monitor vital signs and notify provider if outside of parameters ordered, Monitor for dizziness, Meal and/or fluids consumed at dialysis, For fistulas and grafts, dressings may be removed the evening after treatment." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m. No further information was provided prior to exit. (1) Renvela is used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis. This information was obtained from the following website: Sevelamer: MedlinePlus Drug Information. 2. For Resident #35 (R35) the facility staff failed to evidence communication with the dialysis center on 4/21/2023, 5/3/2023 and 5/17/2023. On the most recent MDS assessment, a quarterly assessment, with an assessment reference date of 4/4/2023, the resident scored a 15 out of 15 on the BIMS score, indicating the resident is not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, R35 was coded as receiving dialysis while a resident at the facility. The dialysis communication book was reviewed for April 2023 through May 31, 2023. There was missing communication for 4/21/2023, 5/3/2023 and 5/17/2023.	F 698		

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F 698	Continued From page 72 A request was made on 6/1/2023 for the missing documents. On 6/1/2023 at 3:43 p.m. ASM (administrative staff member) #2, the director of nursing, stated they didn't have the missing documents. An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/2023 at 1:58 p.m. When asked about the process for when a resident goes to dialysis, LPN #4 stated the nurse should take the resident's vital signs, document in the computer on the dialysis communication form, print the form out and send with the resident. LPN #4 was asked the process for when the resident returns from dialysis, LPN #4 stated the nurse should look at the book to see if the dialysis center filled in their section and see if there is any communication from the dialysis center that needs to be initiated or action taken on. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m. No further information was provided prior to exit.	F 698		
F 713 SS=D	Physician for Emergency Care Available 24 hrs CFR(s): 483.30(d) §483.30(d) Availability of physicians for emergency care The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. This REQUIREMENT is not met as evidenced by:	F 713	F-713 1. Address how corrective action was accomplished for the resident(s) affected. Resident # 65 is no longer in the facility.	

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F 713	Continued From page 73 Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure on-call physician availability 24 hours per day for one of 34 residents, Resident #65. The findings include: For Resident #65, the facility staff failed to ensure the on-call physician responded to an emergency situation phone call on 4/22/23. Resident #65 was admitted to the facility on 10/28/22 with diagnoses that included but were not limited to: CVA (cerebral vascular accident), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), CKD (chronic kidney disease), DM (diabetes mellitus), Cirrhosis of Liver and acute and chronic respiratory failure with hypoxia. A review of the comprehensive care plan dated 10/30/22, which revealed, "FOCUS: At risk for altered cardiac /respiratory status. anemia, CAD (coronary artery disease), hyperlipidemia, pulmonary HTN (hypertension), COPD, with acute and chronic respiratory failure with hypoxia, pleural effusion, patent foramen ovale and GERD (gastro-esophageal reflux disease). INTERVENTIONS: 02 as ordered. Monitor for signs/symptoms of decreased cardiac output, rapid, slow, weak or diminished pulse, hypo/hypertension, dizziness, syncope, dyspnea, chest pain, fatigue, restlessness, cyanosis, altered mental status, congestion and shortness of breath. Notify physician as needed with any changes." A review of the nursing progress note, dated	F 713	2. Address how the facility will identify other residents with potential to be affected. All residents who have had a significant change have the potential to be affected. DON/ designee conducted a quality review of records for residents with changes in condition in the past 72 hours as of 6/6/2023. DON/designee educated nurses where discrepancies were noted. All residents who currently reside in the facility with discrepancies were discussed with the provider with no negative outcomes noted and no new orders received. 3. Address measures to be put in place to ensure deficient practice does not recur. Facility has discussed this situation with the supervisor A new procedure was instituted for failed MD response in a change of condition. If MD does not respond, nurse will notify DON/designee for further instructions. DON/designee will notify the Hopsitalists' Supervisor at home and she will call the doctors.	

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F 713	Continued From page 74 4/22/23 at 8:03 AM included, "Note Text: Resident was seen lethargy, with an oxygen level of 70% at room air during change of shift. resident was repositioned and 15 liter oxygen was administer via non-rebreather mask. resident O@ [sic] went up to 97 % and resident was responsive and having conversion with staff. resident called her full name and was able to identify where she was. O2 level was reduced to 10 liter via non-rebreather mask after resident became stable, alert and oriented X4 and verbally responsive. resident was being monitored every 1 hr. resident retained an oxygen level of 94 to 97% on a simple mask with o2 at 8Lmp. at 0400 resident verbalized abdominal pain and was given hydromorphone 2mg which was effective. at this time, writer called (physician hospital group) on-called [sic] and was awaiting a call back to discuss resident's condition with the DR. but to no avail. at 5 am, resident was stable and resting in bed with an O2 level of 94% via simple mask. at 0540, resident was seen unresponsive. there was no pulse or respiration noted. Writer began CPR and another nurse called 911. 911 arrived at about 0559 and began high pressure CPR. resident could not be resuscitated and was pronounce [sic] dead at about 0626. Resident is he [sic] own responsible party..." An interview was conducted on 6/3/23 at 8:32 AM with LPN (licensed practical nurse) #3. When asked to describe the physician coverage, LPN #3 stated, "If it is 7:00 AM-7:00 PM a NP (nurse practitioner) or physician is usually on site. 7:00 PM-7:00 AM, we have to go through the hospital and have the on-call physician paged. We have been having some difficulty and our director of nursing said to start documenting when they do not call back."	F 713	4. Indicate how facility will monitor performance to ensure solutions are sustained. DON/ designee will audit resident records/ incident notes for MD response during morning meeting x12 weeks starting on 6/19/23. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/2023.	

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F 713	Continued From page 75 An interview was conducted on 6/3/23 at 8:55 AM, with RN (registered nurse) #3. When asked to describe physician coverage, RN #3 stated, "On day shift we call their phone and they are available. There is an on-call physician for nights, I have never had to use them." An interview was conducted on 6/3/23 at 9:05 AM, with LPN #4. When asked to describe physician coverage, LPN #4 stated, "We call the physician and if no response or the condition worsens, then we immediately call 911." When asked how frequently the on-call physicians do not respond, LPN #4 stated, "It is better recently. It used to happen frequently at nights and then we would send the resident out by 911." An interview was conducted on 6/3/23 at 9:10 AM with ASM (administrative staff member) #4, the nurse practitioner (NP). When asked to describe the physician/NP notification process, ASM #4 stated, "The staff have our phone numbers to call us till 7:00 PM. After 7:00 PM, they call the on-call physician at the hospital. We did not receive notification to my knowledge on this resident." An interview was conducted on 6/2/23 at 9:49 AM with RN (registered nurse) #2, who was the nurse on duty at the time of the event. When asked to describe the events of 4/21/23-4/22/23 with Resident #65, RN #2 stated, "I got there late, between 11:30 PM-12:00 AM on 4/21/23. I made my rounds and the resident was laying across the bed. Her oxygen (O2) was not on. She was lethargic. Her vital signs were normal and O2 saturation was low about 77-78%. I increased her to 15 LNC (liters nasal cannula), got her	F 713		

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F 713	Continued From page 76 situated and her O2 saturation came up to 92-93%. Then she was alert and oriented." RN #2 stated, "I kept monitoring her oxygen and trying to decrease it. I could not get it back to 4 LNC because her saturation would drop. I had her on a rebreather and finally got her down to 8 liters. I told her that I have to send her to the hospital. She did not want to go. She started having stomach pain, so I gave her narcotic for the pain." RN #2 stated, "At 4:00 AM, I called the hospital doctor exchange. I did not get a call back. I called the DON (director of nursing) to let her know of the situation. Resident was reassessed with O2 saturation in 90's on the 8 L face mask. About 5:00 AM, I called the hospital doctor exchange again, talked to resident, and said I have to send you out but the Resident refused to go." RN #2 added, "I was the only nurse on the unit, with one CNA...around 5:40 AM, I went to check on (Resident #65) and she was unresponsive. I put her on the floor and started CPR (cardiopulmonary resuscitation)." When asked if there were orders to adjust the oxygen, RN #2 stated, "No, there was no order. We have standing orders, but they do not cover higher oxygen. I could not keep her on that low oxygen rate. That's the reason I called the physician exchange and the DON. The resident was stable on the higher oxygen, she was not critical at the time, so I did not call 911. I did my due diligence and got her oxygen saturation back up by increasing her oxygen level." An interview was conducted on 6/2/23 at 11:10 AM with ASM #7, the medical director. When asked to describe the physician notification process, ASM #7 stated, "The staff have our cell phones. The physicians are one week on and one week off. There is a NP at facility. After 7:00 PM,	F 713		

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F 713	Continued From page 77	F 713		

staff call the hospital exchange, to reach the physician on call. Response time goes to operator and pages the hospitalist very quickly with a response time of usually 15-30 minutes. There have been instances of on-call physicians not responding, but not recently, for about the last two months."

On 6/2/23 at approximately 11:35 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services was made aware of the findings.

An interview was conducted on 6/2/23 at 11:37 AM, with ASM #2, the director of nursing, who stated, "We have had problems with reaching the physician on call, not all the time. It has happened, not sure how frequent. If the staff call me, I tell them to send the resident out if the physician has not responded."

An interview was conducted on 6/2/23 at 11:40 AM, with ASM #1, the administrator, who stated, "We have notified the person in charge of the on-call physicians, who is the manager of the physician group. It has gotten better since that conversation."

A request for a list of residents with a significant change in condition, list of residents who have expired, and a list of residents who were transferred to the hospital from 1/1/23 to 6/1/23 had been requested and received. Residents #58, #60 and #272 were assessed to confirm physicians were notified of a significant change in condition. Two residents, Residents #58 and #60 were transferred to the hospital and returned to the facility with no concerns regarding care they

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F 713	Continued From page 78 were provided. Resident #272 was placed in hospice and expired in the facility. No pattern of failure to provide physician services 24 hours per day was found. Evidence of any conversation, data related to on-call physician response time was requested. On 6/2/23 at 12:40 PM, the surveyor was informed there was no further information. A review of the facility's "Physician Coverage" policy, dated 11/2020, revealed, "The community will ensure that residents have access to physician services, including coverage in the event the primary physician/provider is unavailable. Nurse Practitioners and Physician Assistants, where allowed by licensing law and scope of practice, may serve as back-up providers to attending physicians. Physicians/providers will maintain a visit schedule in accordance with state and federal guidelines. Each attending physician/provider will be responsible for notifying the facility of who their covering provider is and how to contact them in the event they will be unavailable due to vacation, illness, etc. In the event that the attending physician/provider or their covering physician/provider cannot be reached then the facility should contact its Medical Director. In the event that the Medical Director is not available or unreachable and no other facility credentialed physician/provider can be reached, the facility should utilize emergency services and local hospital/emergency room physicians." No further information was provided prior to exit.	F 713		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

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(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 732	Continued From page 79 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 732	F – 732 1. Address how corrective action was accomplished for the resident(s) affected. On 6/1/2023 staff posting was updated and posted by DON during the survey. No residents experienced negative outcomes. 2. Address how the facility will identify other residents with potential to be affected. All residents have the potential to be affected. Regional Director of Clinical Services rounded to ensure the staff posting was correct and up to date x3 days beginning 6/2/2023. 3. Address measures to be put in place to ensure deficient practice does not recur. RDCS/ designee educated administrator and nursing administration on 6/12/23 of the requirements for nursing staff posting. Any new hires involved in this process will receive this education in orientation process starting 6/13/2023.	

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	495431	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 732	Continued From page 80 Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post current daily nurse staffing information for two of three survey dates. The findings include: The facility staff failed to post nurse staffing information on 5/31/2023 and 6/1/2023 prior to the beginning of the nursing staff work shift. On 5/31/2023 at 11:47 a.m. and 4:15 p.m., observations of the staff posting in the front lobby of the facility revealed a schedule documenting a weekly staff posting with scheduled and actual worked hours for staff dated 5/3/23 through 5/7/23. On 6/1/2023 at 7:55 a.m., observations of the staff posting in the front lobby of the facility revealed a schedule documenting a weekly staff posting with scheduled and actual worked hours for staff dated 5/3/23 through 5/7/23. On 6/01/2023 at 8:06 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the scheduler was responsible for posting the daily staffing information but they had left a couple of weeks ago. ASM #2 stated that they, and the assistant director of nursing, were working to get a handle on things now and the posted staffing information was old. ASM #2 stated that they normally post a week at a time what was scheduled and then post the actual hours each day. The facility policy, "Daily Nurse Staffing Posting Policy" with a revision date of 8/13/2020	F 732	4. Indicate how facility will monitor performance to ensure solutions are sustained. DON/ designee will round daily to ensure nursing department staffing is posted every day x 12 weeks starting 6/19/23. Any identified negative findings will be corrected. QAPI committee will review,processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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F 732	Continued From page 81 documented in part, "...The facility will post the following information on a daily basis, at the beginning of each shift: Facility name; The current date; Resident census; The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (a) Registered nurses (b) Licensed practical nurses or licensed vocational nurses (as defined under State law) (c) Certified nurse aides..." On 6/2/2023 at 12:42 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the concern. No further information was presented prior to exit.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755	F-755 1. Address how corrective action was accomplished for the resident(s) affected. An audit of resident # 18 medications and orders was conducted by DON/ designee and all medications were available to be administered as ordered on 6/5/2023. The MD was notified of failing to administer medications to resident per physician's orders and no new orders were received. Resident currently resides in facility with no negative outcomes.	

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F 755	Continued From page 82 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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 ensure that medications were available for administration for one of 34 residents in the survey sample, Residents #18. The findings include: For Resident #18 (R18), on 12 occasions in March and April 2023, the facility staff failed to administer physician ordered medications. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/1/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) indicating they were cognitively intact for making daily decisions. On 5/31/2023 at 12:07 p.m., an interview was conducted with R18 in their room. R18 stated that the nurse's frequently ran out of their medications. R18 stated that they kept track of	F 755	2. All residents have the potential to be affected by this deficiency. On 6/9/2023 a report of all medications documented not given due to unavailability was reviewed by DON/ designee for the last 7 days. Any negative findings were followed-up with provider notification. No further orders were given. 3. Address measures to be put in place to ensure deficient practice does not recur In-service was conducted by the DON/ designee to the licensed nursing staff on the requirement that all medications are to be provided as ordered. Education was completed by 6/12/2023. Staff will not be allowed to return to work until they received this education. Any new hires involved in this process will receive this education in orientation process starting 6/13/2023.	

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F 755	Continued From page 83 the medications that they took and how many so they noticed if there was less than the normal amount in the cup when they brought it in the room and questioned the nurses. R18 stated that it happened with multiple medications including their Parkinson's medications, vitamins, supplements and heartburn medication. R18 stated that the nurses told them that they were out of the medication or they could not find it. A review of R18's clinical record revealed the following physician's orders: - "Pantoprazole Sodium (1) Tablet Delayed Release 40 MG (milligram) Give 1 tablet by mouth two times a day for gerd (gastroesophageal reflux disease). Order Date: 01/08/2023." - "Calcitonin (Salmon) Nasal (2) Solution 200 UNIT/ACT (Calcitonin (Salmon)) 1 spray Alternating nostrils one time a day for compression fracture alternate nostrils daily. Order Date: 02/06/2023." - "Nitrofurantoin Macrocrystal (3) Capsule 50 MG Give 2 capsule by mouth at bedtime for Chronic UTI (urinary tract infection) Suppression. Order Date: 02/23/2023." - "Ocuvite-Lutein Tablet (4) (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for supplement. Order Date: 01/08/2023." - "Ropinirole HCl ER (extended release) Tablet (5) Extended Release 24 Hour 12 MG Give 1 tablet by mouth at bedtime for restless leg syndrome. Order Date: 01/08/2023." A review of R18's March 2023 eMAR (electronic medication administration record) failed to reveal evidence that Ocuvite-Lutein was administered on 3/28/2023 at 9:00 a.m., Ropinirole 12 mg on	F 755	4. Indicate how facility will monitor performance to ensure solutions are sustained. The DON/ designee will review the 24 hour report for missing medications in morning meeting x 12 weeks starting 6/19/23. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/230	

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F 755	Continued From page 84 3/9/2023 at 9:00 p.m., Nitrofurantoin 50 mg on 3/22/2023 at 9:00 p.m., and Calcitonin nasal solution on 3/6-3/8/2023 at 9:00 a.m., 3/13-3/15/2023 at 9:00 a.m. and 3/22/2023 at 9:00 a.m. A review of R18's April 2023 eMAR failed to reveal evidence that Pantoprazole 40 mg was administered on 4/26/2023 at 8:00 a.m. and 4/28/2023 at 8:00 a.m. Review of the eMAR notes for R18 documented the medications as not available or on order from the pharmacy for the medications list above. On 6/1/2023 at 11:35 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a resident's medication was not available they checked the extra storage on the medication cart and medication room. LPN #1 stated that if the medication was not available in house they contacted the pharmacy to deliver the medication stat. LPN #1 stated that if they were unable to get the medication delivered stat, they contacted the physician for an alternate order or hold order. LPN #1 stated that if the resident was out of the medication the nurse should call the physician to notify them that the dosage was missed and document in the eMAR notes. The facility policy "Medication Shortages/Unavailable Medications" with a revision date of 1/1/2022 documented in part, "...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of	F 755		

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F 755	Continued From page 85 medication administration, Facility staff should immediately take action to notify the Pharmacy...If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery, if medically necessary...If the medication is unavailable from Pharmacy or a Third Party Pharmacy, and cannot be supplied from the manufacturer, Facility should obtain alternate Physician/Prescriber orders, as necessary...When a missed dose is unavoidable, Facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR and in the nurse's notes per Facility policy. Such documentation should include the following information: 9.1 A description of the circumstances of the medication shortage; 9.2 A description of Pharmacy's response upon notification; and 9.3 Action(s) taken." On 6/1/2023 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were made aware of the above concern. Reference: (1) Pantoprazole is used to treat damage from gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach) in adults and children 5 years of age	F 755		

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F 755	Continued From page 86	F 755		

and older. Pantoprazole is used to allow the esophagus to heal and prevent further damage to the esophagus in adults with GERD. This information was obtained from the website: Pantoprazole: MedlinePlus Drug Information

(2) Calcitonin salmon is used to treat osteoporosis in women who are at least 5 years past menopause and cannot or do not want to take estrogen products. Osteoporosis is a disease that causes bones to weaken and break more easily. Calcitonin is a human hormone that is also found in salmon. It works by preventing bone breakdown and increasing bone density (thickness). This information was obtained from the website: Calcitonin Salmon Nasal Spray: MedlinePlus Drug Information

(3) Nitrofurantoin is used to treat urinary tract infections. Nitrofurantoin is in a class of medications called antibiotics. It works by killing bacteria that cause infection. Antibiotics such as nitrofurantoin will not work for colds, flu, or other viral infections. Using antibiotics when they are not needed increases your risk of getting an infection later that resists antibiotic treatment. This information was obtained from the website: Nitrofurantoin: MedlinePlus Drug Information

(4) Uses of Ocuvite: It is used to help growth and good health. It may be given to you for other reasons. Talk with the doctor. This information was obtained from the website: Ocuvite: Indications, Side Effects, Warnings - Drugs.com

(5) Ropinirole is used alone or with other medications to treat the symptoms of Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle

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F 755	Continued From page 87 control, and balance), including shaking of parts of the body, stiffness, slowed movements, and problems with balance. Ropinirole is also used to treat restless legs syndrome (RLS or Ekbom syndrome; 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). Ropinirole is in a class of medications called dopamine agonists. It works by acting in place of dopamine, a natural substance in the brain that is needed to control movement. This information was obtained from the website: Ropinirole: MedlinePlus Drug Information	F 755		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842	F – 842 1. Address how corrective action was accomplished for the resident(s) affected. On 6/15/23 an assessment of resident #58 extremity was conducted by an RN to assess for any obvious negative outcome. No negative findings were observed. Resident #58 remains in the facility. Resident #268 no longer resides in facility. No negative outcome for resident #268.	

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F 842	Continued From page 88 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 842	2. Address how the facility will identify other residents with potential to be affected. a. Any resident with a PICC line has the potential to be affected. Any resident who has a PICC line currently as of 6/12/2023 will be audited to ensure all documentation is complete. All new orders that are obtained for removal of PICC line will include documentation of measurements upon removal. b. Any resident has the potential to be affected. An audit of ADL documentation for residents' continence care for the last 72 hours and any areas of concerned and reviewed and documentation was updated. Any areas of concern that could not be corrected, resident will have an assessment for significant change of condition completed to ensure no negative resident outcomes.	

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F 842	Continued From page 89 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure complete and accurate documentation for two of 34 residents, Resident #58 and Resident #268. The findings include: 1. For Resident #58, the facility staff failed to document the removal of a PICC line (1), to include the length of the catheter removed. The physician order dated 5/23/2023, documented, "DC (discontinue) PICC line one time only for 1 day." A request was made on 6/1/2023 at 12:06 p.m. for the documentation of the removal of the PICC line. On 6/1/2023 at 1:14 p.m., ASM (administrative staff member) #2, the director of nursing, presented the May 2023 MAR (medication administration record) that documented the above order. The order was signed off as completed by RN (registered nurse) #4. When asked where the documentation of the length of the catheter that was removed was, ASM #2 stated, "It should be documented, but I don't see it." An interview was conducted with RN #4 on 6/1/2023 at 2:03 p.m. RN #4 had approached the surveyor to state, " I was on my way off shift for	F 842	3. Address measures to be put in place to ensure deficient practice does not recur. The DON/ designee educated licensed nurses on PICC line care policy and removal to include proper documentation required. Education was completed on 6/8/2023. DON/ designee will educate all nursing assistants on proper documentation of resident's ADLs with an emphasis on continence on 6/16/23. Staff will not be allowed to return to work until they received this education. Any new hires involved in this process will receive this education in orientation process starting 6/9/23 for PICC care and 6/19/23 for ADLs.	

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F 842	Continued From page 90 the day. I didn't have the resident, but I was the only RN on duty that day. They asked me to take it out." When asked about the process she followed, RN #4 stated "I did hand hygiene, talked to the resident, told them to hold their breath and turn their head away from me. I made sure I had the head of the catheter was at the top." RN #4 was asked if she measured the catheter after it was removed, RN #4 stated she looked at the tube itself. RN #4 stated there was nothing in the chart (medical record) to compare it to. RN #4 stated, "What I didn't do was put a note in the record. I made sure the family was aware of it being removed." The facility policy, "Central Vascular Access Device (CVAD) Removal (Non-Tunneled)," documented in part, "Documentation in the medical record includes, but is not limited to:32.1 Date and time. 32.2 Reason for removal. 32.3 Length and condition of catheter and tip. 32.4 Site assessment. 32.5 Patient response to procedure. 32.6 Any action taken if catheter was removed due to complication. 32.7 Patient/significant other teaching." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/31/2023 at 4:38 p.m. No further information was provided prior to exit. (1) PICC - Peripherally inserted central catheter, is a long-line catheter made of soft silicone or Silastic material that is placed peripherally but delivers medications and solutions centrally. Lippincott, Williams & Wilkins, Fundamental of	F 842	4. Indicate how facility will monitor performance to ensure solutions are sustained. DON/ designee will audit all residents with PICC lines in the morning meeting x 12 weeks starting 6/19/23 to ensure measurements are documented with the removal of PICC lines. DON/designee will audit incontinent care documentation starting 6/19/23 in the morning meeting to ensure it has been properly documented. Any identified negative findings will be reviewed and corrected as appropriate. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23	

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	495431	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 842	Continued From page 91 Nursing, 5th edition, 2007, page 1423. 2. For Resident #268, the facility staff failed to evidence complete and accurate documentation for bladder and bowel elimination continence status. Resident #268 was admitted to the facility on 8/15/22 with diagnoses that include but are not limited to: stroke, and hemiplegia. Resident #268's most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an assessment reference date of 8/21/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of MDS Section H-Bowel and Bladder: coded the resident as always continent for bladder and bowel. A review of the ADL (activities of daily living) record for August 2022 revealed missing bladder and bowel elimination continence status documentation for 2 out of 16 day shifts, 15 out of 17 evening shifts and 11 out of 17 night shifts. A review of the ADL record for September 2022 revealed missing bladder and bowel elimination documentation for 4 out of 23 day shifts, 20 out of 22 evening shifts and 16 out of 22 night shifts. An interview was conducted on 9/1/23 at 1:00 PM with LPN (licensed practical nurse) #2. When asked if she remembered Resident #268, LPN #2 stated, "Yes, she...was very non-compliant. There were so many safety concerns and she would change position by immediately standing up and going to the bathroom. She was continent of both bowel and bladder but did not ring her bell	F 842		

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F 842	Continued From page 92 for assistance..." An interview was conducted on 9/1/23 at 2:15 PM with CNA (certified nursing assistant) #1 who stated the resident was was continent and would go to the bathroom on her own. When asked if the resident being continent should be documented on the ADL record, CNA #1 stated, "Yes, it should." When asked what the blanks in documentation meant, CNA #1 stated, "Well, since she was continent, it means that the documentation was not complete." On 6/1/23 at approximately 4:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the findings. There is no facility policy regarding a complete and accurate medical record. No further information was provided prior to exit.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		

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F 883	Continued From page 93 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883	F-883 1. Address how corrective action was accomplished for the resident(s) affected. Pneumonia vaccine will be offered to resident #58 and resident # 35. Resident # 58 wants the PNA and was administered on 6/15/2023. Resident number #35 refused stating he had the vaccine "last October". Vaccines will be administered based on resident/responsible party consent and this will be documented in their medical record. 2. Address how the facility will identify other residents with potential to be affected. An audit will be completed on all residents by 6/9/25 by DON/designee. Any residents who are missing vaccinations will be educated and offered the vaccinations as appropriate based on physician's orders. Vaccinations will be given based on consent of resident/RP and MD orders. The medical records will be updated to reflect vaccination status.	

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F 883	Continued From page 94 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed ensure two of five residents, reviewed for immunization status, had evidence of pneumococcal immunizations in the clinical record, Residents #35 and #58. The findings include: 1. The facility staff failed to evidence documentation in the clinical record of a pneumococcal immunization for Resident #35 (R35). On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/4/2023, the resident was coded in Section O - Special Treatments, Procedures and Program, as not having received the pneumococcal immunization and coded as not having been offered. On 6/2/2023 at 9:51 a.m. ASM (administrative staff member) #3, the assistant director of nursing/infection preventionist, presented documentation of Resident #35's pneumococcal immunization they received on 10/15/2020. When asked where the documentation came from, ASM #3 stated it came from an outside source and was not in the clinical record. The facility policy, "Resident Vaccination Policy, documented in part, "Residents and/or their responsible party will be asked about prior vaccinations at admission. Prior doses of	F 883	3. Address measures to be put in place to ensure deficient practice does not reoccur. In-service to be provided by the DON/designee to licensed nurses in regards to Vaccination Policy. Education was completed on 6/12/2023. Staff will not be allowed to return to work until they received this education. Any new hires involved in this process will receive this education in orientation process starting 6/13/2023.	

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F 883	Continued From page 95 influenza, pneumococcal, COVID-19, and other vaccines will be documented in the immunization portal in the electronic health record. Influenza, pneumococcal, and COVID vaccination will be offered to all residents and administered per provider orders. Any vaccines ordered will be administered within 7 days of order. The date of historical vaccination[s] will be documented in the health record immunization portal on admission and as information becomes available. Vaccination information may be obtained from the resident/responsible party, past medical records, VIIS documentation, etc. If specific historical vaccination information is not known the resident/representative will provide their best estimate of dates of prior vaccinations and where received. The Infection Preventionist will track resident immunizations and holds the responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were made aware of the above concern on 6/2/2023 at 12:40 p.m. No further information was provided prior to exit. 2. The facility staff failed to evidence documentation in the clinical record of a pneumococcal immunization for Resident #58 (R58). On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/10/2023, the resident was coded in Section O - Special Treatments, Procedures and Program, as not	F 883	4. Indicate how facility will monitor performance to ensure solutions are sustained. The DON/ designee will conduct a weekly audit x 12 weeks starting 6/19/23 of admissions to ensure vaccinations are given to residents based on consent and physician orders. Medical records will be updated to reflect vaccination status. Any identified negative findings will be corrected. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date when corrective actions are completed. 6/21/23.	

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F 883	Continued From page 96 having received the pneumococcal immunization and coded as not having been offered. On 6/2/2023 at 9:51 a.m., ASM (administrative staff member) #3, the assistant director of nursing/infection preventionist stated she could not find any documentation in the clinical record related to the pneumococcal immunization for Resident #58. The facility policy, "Resident Vaccination Policy, documented in part, "Residents and/or their responsible party will be asked about prior vaccinations at admission. Prior doses of influenza, pneumococcal, COVID-19, and other vaccines will be documented in the immunization portal in the electronic health record. Influenza, pneumococcal, and COVID vaccination will be offered to all residents and administered per provider orders. Any vaccines ordered will be administered within 7 days of order. The date of historical vaccination[s] will be documented in the health record immunization portal on admission and as information becomes available. Vaccination information may be obtained from the resident/responsible party, past medical records, VIIS documentation, etc. If specific historical vaccination information is not known the resident/representative will provide their best estimate of dates of prior vaccinations and where received. The Infection Preventionist will track resident immunizations and holds the responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were made aware of the above	F 883		

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F 883	Continued From page 97 concern on 6/2/2023 at 12:40 p.m. No further information was provided prior to exit.	F 883		