STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495396	A. BUILDING _____ B. WING _____	C 06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HILL HEALTH AND REHAB CENTER	6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/05/23 through 06/07/23. 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 6/5/2023 through 6/7/2023. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during the survey (VA00058621-substantiated with deficiency, VA00056514-unsubstantiated, VA00055316-unsubstantiated, VA00054355-unsubstantiated). The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 131 at the time of the survey. The survey sample consisted of 33 current resident reviews and 8 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		7/22/23

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

Electronically Signed | 06/21/2023

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F 578	Continued From page 1 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 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 offer information related to developing an advance directive for one of 41 residents in the survey sample, Resident #123. The findings include:	F 578	1) Resident #123 no longer resides in the center. 2) Any resident is at risk of staff failing to offer an Advance Directive. A review of current residents was completed to ensure Advance Directive offered. 3) The Administrator or designee will be	

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F 578	Continued From page 2 For Resident #123 (R123), the facility staff failed to evidence that information related to developing an advance directive was offered to the resident. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 5/26/2023, the resident score 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. The Social Services Admission Assessment, dated 5/25/2023, documented in part, "Advance Directive and Code Status" documented the resident did not have an advance directive, or durable DNR (do not resuscitate). The form further documented, "If no Advanced Directives exist, information and assistance to complete Advance Directives has been offer." This part of the form was blank. Nothing was documented in the answers of "Yes, No or Not offered due to cognitive status of resident." On 6/7/2023 at 2:10 p.m. an interview was conducted with OSM (other staff member) #3, the social services case coordinator, who stated the process for determining if the resident has an advance directive upon admission is it is discussed during the safe transition meeting. OSM #3 was asked where it was documented, OSM #3 stated on the social services admission assessment. The above social services admission assessment was reviewed with OSM #3. OSM #3 stated she must have missed that question and cannot recall if she offered information about advance directives to R123.	F 578	re-educating social work department on Advance Directive policy. 4) The Administrator or designee will audit new admissions to ensure Advance Directive offered 2 x weekly x 12 weeks and report findings to QAA committee. 5) Date of compliance 07-22-23	

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F 578	Continued From page 3 The facility policy, "Advance Directives" documented in part, "If an Advance Directive does not exist, the Resident or legal representative will be informed of and given the opportunity to formulate an Advance Directive." ASM #1, the administrator, ASM #2, and ASM # 3, the clinical services specialist, were made aware of the above concern on 6/7/2023 at 1:46 p.m. No further information was obtained prior to exit.	F 578		
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	F 622		7/22/23

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F 622	Continued From page 4	F 622		

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; 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-

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F 622	Continued From page 5 (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 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 evidence the required documents were sent to the receiving facility, upon transfer to the hospital for 2 of 41 residents in the survey sample, Residents #51 and #83. The findings include: 1. For Resident #51, the facility staff failed to evidence the documents sent with the resident upon transfer to the hospital on 5/15/2023. The nurse's note dated, 5/15/2023 at 2:50 p.m. documented in part, "Fall at 1426 (2:46 p.m.), resident landed on head with a hard thump. Blood	F 622	1) Resident #51 no longer resides in the center. Resident #83 no untoward effects noted. 2) Residents transferred to the hospital in the last 30 days were reviewed to ensure the required documents were sent to hospital when patient was transferred 3) The DON or designee will re-educate all licensed nurses on emergent and non-emergent transfer policy. 4) The DON or designee will audit hospital transfers 2 x weekly x 12 weeks and report findings to QAA committee. 5) Date of compliance 07-22-23	

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noted to resident left elbow, skin tear. NP (nurse practitioner) notified at 1428 (2:28 p.m.), verbal order to send resident out..."

The SNF/NF to Hospital Transfer Form" dated, 5/15/2023, failed to evidence what documents were sent with the resident to the hospital. The section, "Acute Care Transfer Document Checklist" was blank.

An interview was conducted with LPN (licensed practical nurse) #6 on 6/7/2023 at 10:37 a.m. When asked what documents are sent to the hospital with the resident for an acute change in condition, LPN #6 stated, they should send the face sheet, labs (laboratory tests) if related to why going out, doctor notes, and medication list. When asked if they send the care plan goals with the resident, LPN #6 stated she would have to check on that. She stated they send the eInteract transfer form that collects information and send that with the resident. When asked where what documents you send, are documented in the clinical record, LPN #6 stated in the nurse's notes.

The facility policy, "Emergency Transfer to Acute Care Hospital" documented in part, "3. The Transfer Envelope and designated EHR copies (current labs/consults/progress notes, e-Interact Transfer Form, face sheet, etc.) are completed and should accompany the patient to the hospital. 4. Medical records pertinent to the acute episode should be included with Emergency Transfer packet to aide in medical history information for the receiving health care center to review. 5. The transfer process may include but it not limited to: a. Obtain an order to transfer the patient, when possible and obtaining the order does not delay

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lifesaving interventions at a higher level of care.
b. Call ambulance for emergency (911).
c. Notify the patient and/or legal representative of reason for transfer and document in the HER.
d. Complete the Emergency Transfer/e-Interact Transfer Form from the EMR.
e. The e-Interact Transfer form should accompany the patient to the Acute Care Hospital.
f. The patient's DDNR (Advanced Directive) must accompany the patient if one has been executed.
6. A PRE-PRINTED Transfer envelope with the "Transfer and Treatment Checklist" and "Bed Hold Policy" attached should accompany the patient to any outside transfers with completed contents inside which coincide with the listed components on the checklist."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical services specialist, were made aware of the above findings on 6/7/2023 at 1:46 p.m.

No further information was provided prior to exit.

2. For Resident #83, the facility staff failed to document what documents were sent with the resident upon transfer on 2/25/2023.

The nurse's notes dated 2/24/2023 at 4:33 p.m. documented, "This nurse witnessed resident walking across the common area. As writer was approaching resident, to guide (them) back to the chair, (they) fell and landed on (their) left side..." The nurse's note dated, 2/24/2023 at 11:45 p.m. documented, "X-ray is - intertrochanteric fracture without shortening. (Name of Doctor). order

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received to send to ED (emergency department)..."

On 6/7/2023 at 10:00 a.m., ASM (administrative staff member) #3, the clinical services specialist, stated they have no evidence of documents sent with the resident upon transfer to the hospital.

An interview was conducted with LPN (licensed practical nurse) #6 on 6/7/2023 at 10:37 a.m. When asked what documents are sent to the hospital with the resident for an acute change in condition, LPN #6 stated, they should send the face sheet, labs (laboratory tests) if related to why going out, doctor notes, and medication list. When asked if they send the care plan goals with the resident, LPN #6 stated she would have to check on that. She stated they send the eInteract transfer form that collects information and send that with the resident. When asked where what documents you send, are documented in the clinical record, LPN #6 stated in the nurse's notes.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical services specialist, were made aware of the above findings on 6/7/2023 at 1:46 p.m.

The facility policy, "Emergency Transfer to Acute Care Hospital" documented in part, "3. The Transfer Envelope and designated EHR copies (current labs/consults/progress notes, e-Interact Transfer Form, face sheet, etc.) are completed and should accompany the patient to the hospital. 4. Medical records pertinent to the acute episode should be included with Emergency Transfer packet to aide in medical history information for

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F 622	Continued From page 9 the receiving health care center to review. 5. The transfer process may include but it not limited to: a. Obtain an order to transfer the patient, when possible and obtaining the order does not delay lifesaving interventions at a higher level of care. b. Call ambulance for emergency (911). c. Notify the patient and/or legal representative of reason for transfer and document in the HER. d. Complete the Emergency Transfer/e-Interact Transfer Form from the EMR. e. The e-Interact Transfer form should accompany the patient to the Acute Care Hospital. f. The patient's DDNR (Advanced Directive) must accompany the patient if one has been executed. 6. A PRE-PRINTED Transfer envelope with the "Transfer and Treatment Checklist" and "Bed Hold Policy" attached should accompany the patient to any outside transfers with completed contents inside which coincide with the listed components on the checklist." 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;	F 625		7/22/23

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F 625	Continued From page 10 (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 three of 41 residents in the survey sample, Residents #51, #83 and #23. The findings include: 1. For Resident #51, the facility staff failed to provide a bed hold notice/policy to the resident and/or responsible party, upon transfer to the hospital on 5/15/2023. The nurse's note dated, 5/15/2023 at 2:50 p.m. documented in part, "Fall at 1426 (2:46 p.m.), resident landed on head with a hard thump. Blood noted to resident left elbow, skin tear. NP (nurse practitioner) notified at 1428 (2:28 p.m.), verbal order to send resident out..."	F 625	1) Resident #51 no longer resides in the center. Resident #83 was given bed hold policy. Resident #23 was given bed hold policy. 2) All residents have the potential to be affected by this deficient practice. A 7-day review of all residents that have transferred to the hospital was completed on 6/21/23 to ensure written information regarding bed-hold policy was received before transfer. Any variances corrected. 3) The Administrator or designee will re-educate the social services department, Admissions department, Business Office, and licensed nurses on the bed-hold policy and process. 4) The DON or designee will audit written bed-hold policy given prior to resident transfer twice weekly for 12 weeks and report findings to QAA committee.	

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F 625	Continued From page 11 The SNF/NF to Hospital Transfer Form" dated, 5/15/2023, failed to evidence what documents were sent with the resident to the hospital. The section, "Acute Care Transfer Document Checklist" was blank. An interview was conducted with LPN (licensed practical nurse) #6 on 6/7/2023 at 10:37 a.m. When asked what documents are sent to the hospital with the resident for an acute change in condition, LPN #6 stated, they should send the face sheet, labs (laboratory tests) if related to why going out, doctor notes, and medication list. LPN #6 was asked if they send the care plan goals with the resident, LPN #6 stated she would have to check on that. LPN #6 stated they send the EInteract transfer form that collects information and send that with them. When asked where what documents are sent are documented in the clinical record, LPN #6 stated in the nurse's notes. LPN #6 was asked if a bed hold notice is provided to the resident upon transfer, LPN #6 stated, the eInteract transfer form collects information and send with them, however she didn't think there was a section for the bed hold. The facility policy, "Bed Hold Prior to Transfer" documented in part, "It is the policy of this Center to provide written information to the patient and/or the patient's legal representative regarding bed hold policies prior to transferring a patient to the hospital or the patient goes on therapeutic leave." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical services specialist, were made aware of the above findings on 6/7/2023 at 1:46 p.m.	F 625	5) Date of compliance 07-22-23	

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No further information was provided prior to exit.

2. For Resident #83, the facility staff failed to provide a bed hold notice/policy to the resident and/or responsible party, upon transfer to the hospital on 2/25/2023.

The nurse's notes dated 2/24/2023 at 4:33 p.m. documented, "This nurse witnessed resident walking across the common area. As writer was approaching resident, to guide (them) back to the chair, (they) fell and landed on (their) left side..." The nurse's note dated, 2/24/2023 at 11:45 p.m. documented, "X-ray is - intertrochanteric fracture without shortening. (Name of Doctor). order received to send to ED (emergency department), RP (responsible party) notified. 911 called."

An interview was conducted with LPN (licensed practical nurse) #6 on 672023 at 10:37 a.m. When asked what documents are sent to the hospital with the resident for an acute change in condition, LPN #6 stated, they should send the face sheet, labs (laboratory tests) if related to why going out, doctor notes, and medication list. LPN #6 was asked if they send the care plan goals with the resident, LPN #6 stated she would have to check on that. LPN #6 stated they send the eInteract transfer form that collects information and send that with them. When asked where what documents you send, are documented in the clinical record, LPN #6 stated in the nurse's notes. LPN #6 was asked if a bed hold notice is provided to the resident upon transfer, LPN #6 stated, the eInteract transfer form collects information and send with them, however she didn't think there was a section for the bed hold.

On 6/7/2023 at 10:00 a.m., ASM (administrative

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F 625	Continued From page 13 staff member) #3, the clinical services specialist, stated they have no evidence of documents sent with the resident or a bed hold notice provided. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, were made aware of the above findings on 6/7/2023 at 1:46 p.m. No further information was provided prior to exit. 3. For Resident #23, the facility staff failed to provide the resident and/or responsible party, with a bed hold notice upon transfer to the hospital on 3/26/2023. The nurse's note dated, 3/26/2023 at 12:06 a.m. documented in part, "Reason for transfer and requires higher level of care: Resident having increased episodes of emesis and decreased BP (blood pressure), last taken was 67/40...Bed Hold Provided: No, left with rescue squad." ASM #3, the clinical services specialist, stated on 6/7/2023 at 12:57 p.m., the facility did not have any documentation of a bed hold notice when sent to the hospital on 3/26/2023. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, were made aware of the above findings on 6/7/2023 at 1:46 p.m. No further information was provided prior to exit.	F 625		
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	F 656		7/22/23

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care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized 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

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F 656	Continued From page 15 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, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for five of 41 residents in the survey sample; Residents #121, #4, #76, #29, #130. The findings include: 1. For Resident #121 the facility staff failed to follow the comprehensive care plan for indwelling catheter care. On 6/6/23 at 8:38 AM, Resident #121 was observed sitting on the side of the bed awaiting his breakfast tray. The catheter drainage bag was noted on the floor under the edge of the bed with the tubing also laying on the floor and the resident stepping on the tubing. A review of the comprehensive care plan revealed one dated 5/21/23 for the use of a Foley catheter which included the intervention, "Provide catheter care per order and protocol and PRN (as-needed)." A review of the physician's orders revealed one dated 5/20/23 for catheter care every shift. On 6/7/23 at 10:37 AM, an interview was conducted with LPN (Licensed Practical Nurse) #6 on. When asked the purpose of the care plan, LPN #6 stated it's to be able to look at it to see what care is to be provided to the resident and	F 656	1) Resident #121 no longer resides in the center. Resident #4 no untoward effects noted. Resident #76 care-plan was reviewed and revised to include c-pap. Resident #29 no untoward effects noted. Resident #130 no longer resides in the center. 2) All residents have the potential to be affected by this deficient practice. A review of resident care-plans will be conducted to ensure residents comprehensive care-plans updated based on their most recent MDS assessment. 3) The Clinical Reimbursement Specialist will educate MDS Nurses on completion of care plans associated with the completion of any comprehensive MDS. Care plans will be completed within 7 days of CAA completion on comprehensive assessments. 4) MDS Nurse / Designee will audit 10 residents care plans for accuracy based on MDS assessment and active care needs weekly for 4 weeks and then monthly for 2 months. Results will be provided and reviewed by the QAA committee. 5) Date compliance 07-22-23	

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the care plan should always be followed; that's the purpose of the care plan.

On 6/7/23 at 11:50 AM an interview was conducted with CNA (Certified Nursing Assistant) #2. She stated that the catheter bag should be hanging on the side of the bed and neither the bag nor the tubing should be on the floor.

On 6/7/23 at 11:52 AM an interview was conducted with LPN (Licensed Practical Nurse) #4. She also stated that neither the bag nor the tubing should be on the floor and the bag should be hanging on the side of the bed.

On 6/7/23 at 2:03 PM in a follow up interview with LPN #4 when asked if the care plan documented to provide Foley care per protocol and the bag and tubing was on the floor, was the care plan being followed, she stated it was not. When asked what was the purpose of the care plan was, she stated it is to guide care to meet the resident's goals.

On 6/7/23 at 2:00 PM the facility policy, "Urinary Catheterization/Irrigation" was provided and reviewed. This policy documented, "The plan of care will address the use of an indwelling/external urinary catheter, including strategies to prevent complications.....Indwelling urinary catheters will be secured with use of an anchor to prevent excessive tension on the catheter, prevent accidental dislodgement, prevent kinks in the tubing and facilitate adequate flow of urine..." The policy did not specify the need for the bag and tubing to be maintained off the floor to prevent infections.

On 6/7/23 at 2:10 PM, after a review of the above

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policy ASM #2 (Administrative Staff Member) the Director of Nursing and ASM #3, Clinical Services Specialist, were made aware of the findings. When asked what complication is the resident at risk for with the Foley catheter and bag being on the floor, ASM #2 stated, "Infections."

No further information was provided by the end of the survey.

2. For Resident #4 (R4), the facility staff failed to implement fall mats when the resident was in bed per the care plan.

The comprehensive care plan dated, 8/23/2022, documented in part, "Focus: (R4) has had actual fall with injury. Cognitive impairment impacting ability to understand own physical limitations. Poor balance, unsteady gain. Resident has had an unwitnessed fall from the bed to the floor with no injury. (R4) fell after attempting to self-ambulate with no injuries, injured when transferring self." The "Interventions" dated 8/23/2022, documented in part, "Fall Mat."

Observations were made of R4 on 6/6/2023 at 9:41 a.m. and at 9:54 a.m. R4 was lying in their bed, on their side, and appeared to be asleep. Two fall mats were located behind the headboard against the wall.

The physician orders dated, 6/2/2023, documented, "Fall mats on both sides of the bed while in bed."

The Kardex for R4 documented in part, "Fall mat on left side of bed while in bed every shift. May have bed side on mats on each side of bed."

An interview was conducted with LPN (licensed

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practical nurse) #6 on 6/7/2023. When asked the purpose of the care plan, LPN #6 stated it's to be able to look at it to see what care is to be provided to the resident, and stated the care plan should always be followed, since that's the purpose of the care plan.

ASM #1, the administrator, ASM #2, and ASM # 3, the clinical services specialist, were made aware of the above concern on 6/7/2023 at 3:33 p.m.

No further information was obtained prior to exit.

3. For Resident #76, the facility staff failed to develop the comprehensive care plan for CPAP (continuous positive airway pressure) use.

Resident #76 was admitted to the facility on 10/22/22 with diagnoses that included but were not limited to: congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD).

A review of the comprehensive care plan dated 11/30/22 revealed, "FOCUS: Resident has respiratory problems (COPD) related to acute illness or chronic condition. INTERVENTIONS: Provide oxygen as ordered. Report changes in breathing patterns or difficulty breathing including wheezing, shortness of breath, rales, rhonchi, note on observation and/or auscultation for further assessment by nurse or physician/physician assistant/nurse practitioner."

A review of the physician orders dated 11/29/22, revealed, "Oxygen at 2 liters/minute via Nasal cannula every shift. CPAP with oxygen at 2L. Apply at HS (bedtime), remove in AM (morning) every shift."

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An interview was conducted on 6/7/23 at 10:50 AM with RN (registered nurse) #1. Asked to describe the purpose of the care plan, RN #1 stated, the purpose is to outline the specific care and interventions for a resident. Asked if CPAP (continuous positive airway pressure) should be on the care plan, RN #1 stated, yes, it should be.

On 6/7/23 at approximately 1:35 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical services specialist was made aware of the findings.

No further information was provided prior to exit.

4. For Resident #29, the facility staff failed to implement the comprehensive care plan for dialysis communication.

Resident #29 was admitted to the facility on 4/22/23 with diagnoses that included but were not limited to: end stage renal disease (ESRD) with dialysis.

A review of the comprehensive care plan dated 4/22/23 revealed, "FOCUS: Resident has renal disease requiring dialysis. INTERVENTIONS: Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes."

A review of the physician orders dated 4/24/23, revealed, "Resident receives Dialysis as follows: Tuesday, Thursday and Saturday with a 5:00 AM chair time. Diagnosis ESRD."

The facility failed to provide communication to the

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dialysis facility for 4 out of 20 visits in April and May 2023 specifically on 4/25/23, 4/27/23, 5/6/23 and 5/9/23.

An interview was conducted on 6/6/23 at 3:00 PM with LPN (licensed practical nurse) #1. When asked to describe the purpose of the care plan, LPN #1 stated, the purpose is to outline the specific care and interventions for a resident. When asked if the care plan was being followed when the dialysis communication forms are not completed for each dialysis treatment, LPN #1 stated, no, the care plan is not being followed.

On 6/7/23 at approximately 1:35 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical services specialist was made aware of the findings.

No further information was provided prior to exit.
5. For Resident #130 (R130), the facility staff failed to implement the resident's comprehensive care plan for a Hoyer lift transfer on 3/8/23.

R130's comprehensive care plan revised on 3/2/23 documented, "(R130) demonstrates the need for ADL (activities of daily living) assistance r/t (related to) weakness d/t (due to) cerebral infarction (stroke), Stage IV breast cancer, medication, and medical deficit. Interventions/Tasks: Resident Hoyer lift/two person assist with transfers..." R130's CNA (certified nursing assistant) kardex dated 3/8/23 documented, "Transferring 2 person/Hoyer..."

On 6/6/23 at 10:22 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that on 3/8/23, she entered R130's

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room and two CNAs were attempting to transfer the resident (without a Hoyer lift) from the bed to a shower chair. LPN #3 stated the CNAs were struggling, so she assisted with the transfer. LPN #3 stated that at the time, she and the CNAs were not aware that they were supposed to use a Hoyer lift. LPN #3 stated R130's transfer status must have recently changed prior to 3/8/23. LPN #3 stated R130's son, who was present in the room, complained after R130's transfer to the shower chair. LPN #3 stated that after R130's son complained, she looked at R130's kardex and saw that the transfer without a Hoyer lift was an error on her and the CNAs part. (A review of nurses' notes for 3/8/23 failed to reveal documentation regarding the transfer).

The CNAs who transferred R130 to the shower chair on 3/8/23 were not available for interview during the survey.

On 6/6/23 at 2:47 p.m., an interview was conducted with CNA #1. CNA #1 stated CNAs are made aware of residents' need for a Hoyer lift via the kardex, dialog with therapy staff, dialog with the unit manager, and in the CNA verbal report.

On 6/7/23 at 1:05 p.m., an interview was conducted with LPN #6 regarding the implementation of care plans. LPN #6 stated the CNAs can look up information on the kardex and go to their nurses for clarification, and nurses can look at the care plan.

On 6/7/23 at 1:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to review and revise the comprehensive care for two of 41 residents in the survey sample, Residents #23 and #83. The findings include:	F 657	1) Resident #23 care-plan reviewed and revised to include bowel obstruction. Resident #83 care plan reviewed and revised to include fall with hip fracture. 2) Current Residents that have fallen with injury in the last 30 days and current Residents that experienced a significant change in condition in the last 30 days	7/22/23

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F 657	Continued From page 23 1. For Resident #23 (R23), the facility staff failed to review and review the comprehensive care plan after the resident was hospitalized with a small bowel obstruction. The resident's diagnoses included but was not limited to: personal history of malignant carcinoid tumor of large intestine. The nurse's note dated, 3/26/2023 at 12:06 a.m. documented in part, "Reason for transfer and requires higher level of care: Resident having increased episodes of emesis and decreased BP (blood pressure), last taken was 67/40...left with rescue squad." The comprehensive care plan dated, 3/30/2023, failed to evidence documentation related to the resident's bowel conditions. An interview was conducted with 6/7/2023 at 10:37 a.m. with LPN (licensed practical nurse) #6. When asked who updates the care plans, LPN #6 stated she does on her unit, each department does their section and the MDS (minimum data set) nurse reviews the care plans with each assessment. When asked if a resident returns from the hospital after suffering a small bowel obstruction and having a history of colon cancer, would she expect to see a care plan to address bowel regimen, LPN #6 stated, since it was a new change in condition for the resident, it should be addressed on the care plan to monitor her bowels, and make sure medications are in place, if needed. The facility policy, "Comprehensive Care Planning Process" documented in part, "Additionally, the care plan is a fluid document and shall be	F 657	were reviewed to ensure revision of care plan. 3) The DON or designee will re-educate the Department of Social Services, MDS Department, and all licensed nurses on reviewing and revising the care plans. 4) Administrator or designee will audit 10 residents with a fall with injury or significant change in condition care plans to ensure care-plan is updated weekly for 12 weeks and report findings to QAA committee. 5) Date of compliance is 07-22-23	

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reviewed and updated at any time the resident, family or representative or member of the ID team determines a need for additional interventions or care areas to be addressed."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical services specialist, were made aware of the above findings on 6/7/2023 at 1:46 p.m.

No further information was provided prior to exit.

2. For Resident #83 (R83), the facility staff failed to review and revise the comprehensive care plan after the resident suffered a fall with a broken hip.

The nurse's notes dated 2/24/2023 at 4:33 p.m. documented, "This nurse witnessed resident walking across the common area. As writer was approaching resident, to guide (them) back to the chair, (they) fell and landed on (their) left side. Resident did not hit (their) head..."

The nurse's note dated, 2/24/2023 at 11:45 p.m. documented, "X-ray is - intertrochanteric fracture without shortening. (Name of Doctor). order received to send to ED (emergency department), RP (responsible party) notified. 911 called."

Review of the comprehensive care plan, revised on 2/27/2023, documented in part, "Focus: (R83) had actual falls and continues to be at risk for further falls r/t (related to) unsteady gait, impaired cognition and muscle weakness, fell while attempting to transfer self, fall when ambulating self." The "Interventions" documented in part, dated 2/24/2023, "ER (emergency room). X-ray."

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F 657	Continued From page 25 The "Fall Analysis/Investigation" dated 2/24/2023, documented at the bottom of the first page there was a section, "Care Plan/Individualized Service Plan Review: NEW Recommendations to minimize recurrent fall. Change/modify Care Plan. Care plan Remains Effective, No change Indicated." There were boxes to check off next to each of those statements, however there were no check marks. An interview was conducted with LPN (licensed practical nurse) #6 on 6/7/2023 at 10:37 a.m. When asked who updates the care plans, LPN #6 stated she did on her unit. When asked if "ER" and "X-ray" are interventions to prevent further falls, LPN #6 stated it's an intervention of what is being done at that moment in time. LPN #6 concurred that the care plan should be an reviewed and updated after a resident has suffered a fall with a broken hip, after they return to the facility. On 6/7/2023 at 11:13 a.m. ASM (administrative staff member) #2, the director of nursing, stated there was no review or update to the care plan after (R83's) fall. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical services specialist, were made aware of the above findings on 6/7/2023 at 1:46 p.m. No further information was provided prior to exit.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		7/22/23

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F 684	Continued From page 26 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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to perform blood sugar checks per the physician order for one of 41 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4) the facility staff failed to obtain weekly fingerstick blood sugar on two out of four Wednesdays in the month of May 2023. The physician order dated, 3/15/2023 documented, "Check BS (blood sugar) at HS (bedtime) on Wednesdays (Wed) at bedtime every Wed for DM (diabetes mellitus). Notify MD (medical doctor) if BS greater than 250 or less than 60." The May 2023 Medication Administration Record (MAR) documented the above order. On 5/24/2023 and 5/31/2023, there was no documented blood sugar, just the nurse's initials with a check mark. Review of the "Blood Sugar Summary", failed to evidence the blood sugar reading for 5/24/2023 and 5/31/2023. Review of the nurse's notes failed to evidence	F 684	1) Resident #4 blood sugar order discontinued on 6/20/23. 2) Any resident has the potential to be affected by this deficient practice. A review of residents with physician ordered accuchecks will be completed to ensure that order is entered accurately. 3) The DON or designee will re-educate all licensed nurses on following physician order accuchecks. 4) The DON or designee will audit residents with physician order accuchecks to ensure completed per physician order weekly x 12 weeks and report findings to QAA committee. 5) Date of compliance 07-22-23	

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F 684	Continued From page 27 documentation of the blood sugar readings on 5/24/2023 and 5/31/2023. An interview was conducted with LPN (licensed practical nurse) #6 on 6/7/2023 at 4:08 p.m. When asked if its not documented on the MAR, where would the blood sugar be documented, LPN #6 stated maybe in the nurse's notes. All the above documents were reviewed with LPN #6. LPN #6 was asked how you could tell the blood sugar was completed on those days; LPN #6 stated "I don't know how the nurses bypassed the scheduled blocks to document the blood sugar. We can't tell what the readings were for those days." The facility policy, "Blood Glucose Monitoring," documented in part, "It is the policy of this Center to perform blood glucose monitoring per physician/physician extender's orders. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical services specialist, were made aware of the above findings on 6/7/2023 at 4:35 p.m. No further information was provided prior to exit.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		7/22/23

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F 686	Continued From page 28 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to identify and prevent pressure ulcers/injuries, resulting in harm for two of 41 residents in the survey sample, Residents #47 and #15. The findings include: 1. For Resident #47 (R47), the facility staff failed to identify and prevent pressure injuries until stage three pressure injuries (1) developed on the resident's right buttock and sacrum on 4/12/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/10/23, the resident's cognitive skills for daily decision making were coded as severely impaired. Section G coded R47 as requiring extensive assistance of two or more staff with bed mobility and as being totally dependent on two or more staff with transfers. A review of R47's clinical record revealed a Braden scale for predicting pressure sore risk dated 1/19/23 that documented the resident was at very high risk for developing a pressure injury. R47's comprehensive care plan dated 1/15/20 documented, "(R47) has the potential for	F 686	1) Resident #47 body audit completed on 6/21/23 and areas of current skin impairment assessed, treatment implemented per physician order, and care plan reviewed and revised. Resident #15 body audit completed on 6/21/23 and areas of current skin impairment assessed, treatment implemented per physician order, and care plan reviewed and revised. 2) Any resident has the potential to be affected by this deficient practice. Skin observations were conducted on all residents to identify any additional new areas of impairment. A review of new admission skin impairments will be completed to ensure that appropriate identification of pressure ulcers occurred. 3) The DON or designee will re-educate all licensed nursing staff on timely identification of pressure injuries, body audit policy, and admission skin observation process. 4) A. The DON or designee will randomly review 10 body audits to ensure proper identification and staging of skin impairment weekly x 12 weeks and report findings to the QAA committee. B. The DON or designee will audit new admissions weekly to ensure that	

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alteration in skin integrity d/t (due to) impaired mobility, urinary and bowel incontinence." Multiple interventions including barrier cream, keeping the skin clean and dry, a pressure reduction support surface and turning and repositioning frequently were documented.

A review of R47's clinical record revealed a Braden scale for predicting pressure sore risk dated 1/19/23 that documented the resident was at very high risk for developing a pressure injury.

A review of R47's clinical record revealed a body audit dated 4/6/23 that documented redness to the groin but no other skin impairments. Further review of R47's clinical record failed to reveal documentation regarding the resident's skin until 4/12/23. A nurse's note dated 4/12/23 documented, "redness noted to buttock and intergluteal cleft. N.O. (New Order) Apply Thera Calazinc Body Shield to buttock as needed for Altered skin integrity AND every shift for Altered skin integrity. RP (Responsible Party) aware. MD (Medical Doctor) notified."

A wound care physician note dated 4/12/23 documented, "Wound #1 Right Buttock is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 2.3cm (centimeters) length x (times) 1cm width x 0.1 cm depth, with an area of 2.3 sq cm (square centimeters) and a volume of 0.23 cubic cm. There is a Light amount of serous drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100%, granulation. The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal. Wound #2 Sacral

appropriate identification of pressure ulcer occurred on admission weekly x 12 weeks and report findings to the QAA committee.
5) Date of compliance 07/22/23

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is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 1.5cm length x 0.5 cm width x 0.1 cm depth, with an area of 0.75 sq cm and a volume of 0.075 cubic cm. There is a Light amount of serous drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100%, granulation. The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal."

On 6/7/23 at 1:09 p.m., an interview was conducted with LPN (licensed practical nurse) #2 (the wound care nurse) and ASM (administrative staff member) #2 (the director of nursing). LPN #2 stated that it was accurate that there was no documentation of skin impairment to R47's right buttock or sacrum until the stage three pressure injuries were identified on 4/12/23. LPN #2 stated Braden assessments are completed on admission, quarterly and when skin issues are identified. ASM #2 stated weekly body audits are completed by nurses and residents' skin is observed daily during care provided by the CNAs (certified nursing assistants). ASM #2 stated CNAs should alert nurses of any skin issues then nurses should speak with the doctor and obtain a treatment order.

On 6/7/23 at 2:14 p.m., an interview was conducted with LPN #2, ASM #2 and ASM #3 (the clinical services specialist). LPN #2 stated she had no additional information regarding the development of R47's pressure injuries on 4/12/23. ASM #3 stated an action plan was created and nurses were educated. ASM #3 stated that during the development of the plan, they learned that nurses were not communicating

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excoriation, incontinence associated dermatitis, redness, or even open skin areas that may have been a stage two pressure injury. ASM #3 stated that if barrier cream was in place, then the nurses did not communicate those skin impairments. (Note: an action plan was created on 12/13/22 with an allegation of compliance date of 3/20/23 and another action plan was created on 5/22/23 with an allegation of compliance date of 6/6/23. R47's stage three pressure injuries were identified on 4/12/23).

On 6/7/23 at 3:19 p.m., an interview was conducted with ASM #4 (the wound care physician). ASM #4 stated he tells all staff to tell him or management if they see any skin alterations. ASM #4 stated he only sees a wound when he is told about a wound. ASM #4 stated R47 is at high risk for developing pressuring injuries because the resident requires maximum assistance and is bed bound. ASM #4 stated he could not provide additional information about R47's pressure injuries before he first saw them.

On 6/7/23 at 3:34 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the concern for harm.

The facility policy titled "Body Audit" documented, "Policy:
It is our policy to perform a full body audit as part of the systematic approach to pressure injury prevention and management.
Policy Explanation:
1. A full body, or head to toe, body audit will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The body audit may also be performed after a change of condition or after any newly identified

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pressure injury.
2. Documentation of the body audit in the EHR (electronic health record) includes but it not limited to:
a. Include date and time of the assessment, your name, and position title.
b. Document observations (e.g. skin conditions, how the patient tolerated the procedure, etc.).
c. Document type of wound.
d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain).
e. Document if patient refused assessment and why.
f. Document other information as indicated or appropriate."

Reference:
(1) A stage three pressure injury Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
2. For Resident #15 (R15), the facility staff failed to identify a pressure injury to the sacrum prior to it being an unstageable pressure injury (1) with eschar (black necrotic [dead] tissue).

On the MDS (minimum data set) assessment, prior to the discovery of the pressure injury, a quarterly/significant change assessment, with an assessment reference date of 1/17/2023, the resident was coded as having both short- and long-term memory difficulties. In Section G - Functional Status, R15 was coded as requiring extensive assistance of two or more staff members for moving in the bed. In Section H - Bladder and Bowel, the resident was coded as

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always being incontinent of both bowel and bladder. In Section M - Skin Conditions, the resident was not coded as having any pressure injuries.

The nurse's note dated, 2/14/2023 at 5:30 a.m. documented "Staff reports to this writer that when provided care this morning, observed resident scratching her buttocks causing an open area on right buttock. Open area clean [sic] with wound cleanser and Medihoney applied and covered with foam dressing. Resident tolerated well and denies pain. Resident refusing to allow this nurse to clip fingernails. Resident in bed at this time, MD/NP (medical doctor/nurse practitioner) notified."

The physician orders, dated 2/15/2023, documented, "Clean open area to right buttock with wound cleanser, apply TAO (topical antibiotic ointment) and cover with foam dressing every day shift for altered skin integrity."

The February 2023 MAR (medication administration record) documented the above over. The treatment was documented as performed on 2/15/23 through 2/17/2023.

The physician order dated, 2/18/2023, documented, "Cleanse right buttock with wound cleanser, pat dry, apply betadine topically BID (twice a day), til resolved, two times a day."

The February 2023 MAR documented the above over. The treatment was documented as performed on 2/18/2023 through 2/21/2023.

The "Body Audit" form on 2/11/2023 at 2:14 p.m. documented, "Skin integrity intact? no. Right heel

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- Discoloration/blister, TX (treatment) in place."

The "Body Audit" form for 2/19/2023 at 4:23 a.m. documented, "Skin integrity intact? no. Right buttock - wound on upper right buttock, dressing intact."

A second "Body Audit" form for 2/19/2023 at 6:50 a.m. documented, "Skin integrity intact? no. Right buttock, tx (treatment) initiated."

The nurse's note dated 2/22/2023 at 10:00 a.m. documented, "New pressure injury noted to sacrum. Unable to stage due to slough/eschar coverage of wound bed. Length 6/1 cm (centimeters) X width 3.9 cm, with surface area of 13.8cm2. No measurement of depth noted. No pain/discomfort. Air mattress ordered to be placed on bed, heels were elevated, pillow between knew and ankles for pressure relief. Dietician noted significant weight loss this month. Contractures prevention full ROM (range of motion) and making positioning in bed and chair difficult. Therapy screen request ordered. Wound MD (doctor) to assess on next round date."

The "Skin & Wound Evaluation" dated, 2/22/2023, documented in part, "Describe: pressure. Stage: unstageable - obscured full-thickness skin and tissue loss. Due to: Slough and/or eschar. Location: Sacrum. Acquired: In-house acquired. How long has wound been present? New. Wound measurements: Area - 13.8 cm2. Length: 6.1.cm. Width: 3.9 cm. Wound bed: eschar. % of eschar: 100% of wound filled. Surrounding tissue: Excoriated: superficial loss of tissue."

The "Therapy Screening Request" dated,

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2/22/2023, documented in part, "A. Resident has had a change in status or function and may benefit from therapy services...Other: Difficulty with or maintaining positioning in bed or chair. Loss of joint mobility/contracture risk. Skin integrity issues...Additional Information: New Pressure Injury to sacrum, has contractures, difficult to maintain position in bed/chair. Ordered air mattress for bed."

The comprehensive care plan dated, 10/14/2023 and last revised on 3/23/2023, documented in part, "Focus: (R15) is at risk for skin breakdown r/t (related to) fragile skin, actual impaired skin to bilateral arms, blister to right heel, discolored areas to left foot (resolved) area to sacrum, discolored area to chest. Stage 4 pressure injury to sacrum." The "Interventions" documented in part, "6/6/2023 - air mattress. 10/17/2022 - assess skin thoroughly and implement precautions and/or treatment as indicated. Encourage frequent position changes for pressure relief. Observe for moisture and incontinence issues that affect skin. Report for further assessment, if noted. Provide pressure reduction surfaces as ordered/indicated. Report changes in skin integrity or condition for further assessment and treatment. 3/13/2023 - Reposition resident often while in bed."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing and ASM #3, the clinical services specialist, on 6/7/2023 at 8:33 a.m. When asked to clarify the right buttock wound and the sacral wound, ASM #2 stated the facility has recently had education on anatomical positioning as the floor nurses were incorrect in their description of body part. ASM #3 stated the open area on the

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right buttock was cause by a scratch that was self-inflicted by the resident. Treatment was put in place. Then the sacral pressure injury was noted on 2/22/2023.

An interview was conducted with LPN (licensed practical nurse) #2, the wound nurse, ASM #2 and ASM #3, on 6/7/2023 at 11:14 a.m. When asked to clarify the location of the scratch wound and the sacral wound, LPN #2 stated the right buttock wound was on the right upper outer quadrant of the buttock. When asked, if a nurse is applying a treatment to the right buttock, how did they miss a large sacral wound, ASM #3 stated, they would have expected someone to notify someone about a new area. LPN #2 stated that as soon as she was made aware of the area, she went and assessed it and put treatment orders in place. She further stated the resident was noted to be having a decline and they spoke with the family. ASM #2 stated they recognized that they had a process with skin and they have been aggressively working on skin since 5/24/2023. When stated that this happened prior to 5/24/2023, ASM #2 stated they had a previous action plan in place for skin assessments.

The action plan dated, 12/31/2022, documented in part, "Area of Concern: Body audit and Treatment in place. Corrective Action: 1. Licensed nursing staff failed to complete timely wound assessment and initiate treatment on admission for (other resident initials) 2. Any resident is at risk for not having a complete and accurate body audit on admission. Any resident that has a wound is at risk for not have treatment in place on admission. Date of Compliance: 3/20/2023." The plan was reviewed with ASM #2 and ASM #3 and it was verified that R15 did not appear on any

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audit forms.

An interview was conducted with LPN #6 on 6/7/2023 at 12:57 p.m. LPN #6 stated that she had observed the resident's skin on 2/20/2023 and the sacral wound was not there.

An interview was conducted with CNA (certified nursing assistant) #1 on 6/7/2023 at 1:07 p.m. When asked when she looks at a resident's skin, CNA #1 stated she checks it when she is changing them, showers, baths or providing any care to them. CNA #1 was asked what she does when she finds any new breakdown on the resident's skin, CNA #1 stated she goes to the nurse and tells them. When asked if she documents skin assessments/observations anywhere, CNA #1 stated she documents in the computer program.

An interview was conducted with ASM #4, the wound doctor, on 6/7/2023. When asked what he found when he saw R15 on 2/22/2023. ASM #4 reviewed his progress notes then stated, it was an unstageable due to necrosis wound on the sacrum, it had hard eschar. When asked if a pressure injury like that could develop overnight, ASM #4 stated, with what he saw, it couldn't have developed overnight. ASM #4 stated he was surprised that the wound didn't take the resident's condition in a decline as the wound had done remarkedly well.

ASM #1, the administrator, ASM #2 and ASM #3 were made aware of the concern for harm for R15 on 6/7/2023 at 3:33 p.m.

No further information was provided prior to exit.

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F 686	Continued From page 38 Reference: (1) Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf	F 686		
F 689 SS=D	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 observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to implement safety interventions and/or maintain a safe environment for three of 41 residents in the survey sample, Residents #130, #278 and #4. The findings include: 1. For Resident #130 (R130), the facility staff failed to transfer the resident with a Hoyer lift, per	F 689	1) Resident #130 no longer resides in the center. Disinfection wipes removed from Resident #278□s room on 6/7/23. Resident #4 will be observed to have fall mat in place and any variance noted will be corrected immediately upon observation. 2) Any resident has the potential to be affected by this deficient practice. Room rounds will be conducted to ensure residents do not have disinfecting wipes	7/22/23

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F 689	Continued From page 39 the resident's plan of care on 3/8/23. R130's comprehensive care plan revised on 3/2/23 documented, "(R130) demonstrates the need for ADL (activities of daily living) assistance r/t (related to) weakness d/t (due to) cerebral infarction (stroke), Stage IV breast cancer, medication, and medical deficit. Interventions/Tasks: Resident Hoyer lift/two person assist with transfers..." R130's CNA (certified nursing assistant) kardex dated 3/8/23 documented, "Transferring 2 person/Hoyer..." On 6/6/23 at 10:22 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that on 3/8/23, she entered R130's room and two CNAs were attempting to transfer the resident [without a Hoyer lift] from the bed to a shower chair. LPN #3 stated the CNAs were struggling, so she assisted with the transfer. LPN #3 stated that at the time, she and the CNAs were not aware that they were supposed to use a Hoyer lift. LPN #3 stated R130's transfer status must have recently changed prior to 3/8/23. LPN #3 stated R130's [family member], who was present in the room, complained after R130's transfer to the shower chair. LPN #3 stated that after R130's [family member] complained, she looked at R130's Kardex (a document that gives a brief overview of the resident) and saw that the transfer without a Hoyer lift was an error on her and the CNAs part. (A review of nurses' notes for 3/8/23 failed to reveal documentation regarding the transfer). The CNAs who transferred R130 to the shower chair on 3/8/23 were not available for interview during the survey.	F 689	or cleaning products at the bedside; any items noted will be removed immediately. Residents with fall mats will be observed to ensure fall mats are in place. 100% of care-plans will be reviewed to ensure transfer status is assigned to Kardex. 3) a. The DON or designee will re-educate center staff on maintaining a safe environment for residents to ensure disinfection wipes are not present at bedside and that residents fall mats are in place for the prevention of injury. b. The DON or designee will re-educate all C.N.A.s on review of Kardex prior to resident transfer. 4) The DON or designee will audit 10% of resident rooms to ensure no disinfecting wipes are at beside and fall mats are in place daily x 5 days a week for 2 weeks, weekly for 2 weeks then monthly for 2 months. DON or designee will observe 1 staff transfer daily x 5 days a week for 2 weeks, weekly for 2 weeks then monthly for 2 months to ensure transferring a Resident properly per the Kardex. Findings will be reported to the QAA committee. 5) Date of compliance 07-22-23	

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On 6/6/23 at 2:47 p.m., an interview was conducted with CNA #1. CNA #1 stated CNAs are made aware of residents' need for a Hoyer lift via the Kardex, dialog with therapy staff, dialog with the unit manager, and in the CNA verbal report.

On 6/7/23 at 1:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not have a policy regarding resident transfers.

2. For Resident #278, the facility staff failed to ensure disinfectant wipes were not out in the open in the resident's room.

A nurse's note dated 6/4/23 documented, "Resident confused this shift. Resident knows how old she is but states that her mother is 91 and that she has three babies to take care of, 2 girls and a boy. She was concerned about her mother taking care of the babies and that she stated that she needed to get home. Multiple attempts of reality orientation..."

On 6/5/23 at 12:49 p.m., R278 was lying on the bed and stated she needed to get out to check on the her mother and she needed to get a babysitter for her children. At that time, a container of disinfectant wipes was observed on R278's windowsill.

A nurse's note dated 6/6/23 documented R278's preliminary urinalysis results were indicative of a urinary tract infection and antibiotic therapy was started.

It was documented that R278 required extensive

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assistance with bed mobility and transfers and did not ambulate.

On 6/6/23 at 9:34 a.m., R278 and an employee was observed in the resident's room. The container of disinfectant wipes remained on the windowsill.

On 6/6/23 at 3:57 p.m., an interview as conducted with RN (registered nurse) #3. RN #3 stated disinfectant wipes cannot be kept in residents' rooms because, "It has some kind of chemical component to it." RN #3 stated that usually the nurses have access to disinfectant wipes and can get them if they need them for a resident.

On 6/7/23 at 1:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not have a policy regarding disinfectant wipes.

3. For Resident #4 (R4), the facility staff failed to have fall mats on the floor when the resident was in bed.

Observation was made of R4 on 6/6/2023 at 9:41 a.m. and at 9:54 a.m. R4 was lying in their bed, on their side, and appeared to be asleep. Two fall mats were located behind the headboard against the wall.

The physician orders dated 6/2/2023, documented, "Fall mats on both sides of the bed while in bed."

The comprehensive care plan dated, 8/23/2022, documented in part, "Focus: (R4) has had actual fall with injury. Cognitive impairment impacting ability to understand own physical limitations.

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Poor balance, unsteady gain. Resident has had an unwitnessed fall from the bed to the floor with no injury. (R4) fell after attempting to self-ambulate with no injuries, injured when transferring self." The "Interventions" dated 8/23/2022, documented in part, "Fall Mat."

An interview was conducted with CNA (certified nursing assistant) #4 on 672023 at 2:04 p.m. When asked where she can look to see what safety interventions a resident needs, CNA #4 stated, it is in the Kardex.

The Kardex for R4 documented in part, "Fall mat on left side of bed while in bed every shift. May have bed side on mats on each side of bed."

On 6/7/2023 at 3:53 p.m. ASM (administrative staff member) #2, the director of nursing, was asked should interventions for the prevention of falls be put in place, ASM #2 stated, yes.

The facility policy, "Fall Prevention Program" documented in part, "5. High Risk Protocols: a. The patient will be evaluated by the IDT (interdisciplinary team) for intervention management. b. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. 6. Each patient's risk factors, and environmental hazards will be evaluated when developing the patient's comprehensive plan of care. a. Interventions will be monitored for effectiveness."

ASM #1, the administrator, ASM #2, and ASM # 3, the clinical services specialist, were made aware of the above concern on 6/7/2023 at 3:33

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F 689	Continued From page 43 p.m. No further information was obtained prior to exit.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		7/22/23

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F 690	Continued From page 44 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide appropriate care and services for an indwelling urinary catheter, for one of 41 residents in the survey sample; Resident #121. The findings include: For Resident #121 the facility staff failed to ensure the Foley catheter was maintained off the floor to prevent infections. A Foley catheter is a common type of indwelling catheter. It has soft, plastic or rubber tube that is inserted into the bladder to drain the urine (1). On 6/6/23 at 8:38 AM, Resident #121 was observed sitting on the side of the bed awaiting his breakfast tray. The Foley catheter bag was noted on the floor under the edge of the bed, the tubing was laying on the floor and the resident was stepping on the tubing. A review of the physician's orders revealed one dated 5/20/23 for catheter care every shift. On 6/7/23 at 11:50 AM an interview was conducted with CNA (Certified Nursing Assistant) #2 who stated that the catheter bag should be hanging on the side of the bed and the bag and the tubing should not be on the floor. On 6/7/23 at 11:52 AM an interview was conducted with LPN (Licensed Practical Nurse) #4 who stated that neither the bag nor the tubing	F 690	1) Resident #121 no longer resides in the center. 2) Residents with current orders for indwelling catheters were reviewed to ensure proper placement of catheter bag. 3) The DON or designee will re-educate licensed nurses and C.N.A.s on proper placement of Foley catheter bag to ensure catheter bag is maintained off floor to prevent infection. 4) The DON or designee will complete rounds of 10% of residents with a Foley catheter to ensure proper position and maintained off floor weekly x 12 weeks and report findings to the QAA committee. 5) Date of compliance 07-22-23	

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F 690	Continued From page 45 should be on the floor and the bag should be hanging on the side of the bed. A review of the comprehensive care plan dated 5/21/23 for the use of a Foley catheter included the intervention dated 5/21/23 for "Provide catheter care per order and protocol and PRN (as-needed)." On 6/7/23 at 1:45 PM ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing and ASM #3 Clinical Services Specialist, were made aware of the findings. On 6/7/23 at 2:00 PM the facility policy, "Urinary Catheterization/Irrigation" was provided and reviewed. This policy documented, "...Indwelling urinary catheters will be secured with use of an anchor to prevent excessive tension on the catheter, prevent accidental dislodgement, prevent kinks in the tubing and facilitate adequate flow of urine..." The policy did not specify the need for the bag and tubing to be maintained off the floor to prevent infections. No further information was provided by the end of the survey. Reference: (1) The Foley catheter information was obtained from: https://medlineplus.gov/ency/article/003981.htm#:~:text=A%20Foley%20catheter%20is%20a,smallest%20catheter%20that%20is%20appropriate.	F 690		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		7/22/23

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F 698	Continued From page 46 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. 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 provide dialysis care and services per the comprehensive care plan, for one of 41 residents in the survey sample, Resident #29. The findings include: The facility failed to provide communication to the dialysis facility for 4 out of 20 dialysis center visits in April and May 2023. Resident #29 was admitted to the facility on 4/22/23 with a diagnosis that included but was not limited to, end stage renal disease (ESRD) with dialysis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/23/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 4/22/23, which revealed, "FOCUS: Resident has renal disease requiring dialysis. INTERVENTIONS: Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via	F 698	1) Resident #29 dialysis book updated to include missed communication to dialysis center. 2) All dialysis residents have the potential to be affected by this deficient practice. 3) The DON or designee will re-educate all licensed nurses on Care and Management of a Patient Receiving Hemodialysis policy. 4) DON or designee will randomly audit 3 residents who received dialysis services to ensure proper communication with dialysis center weekly x 12 weeks and report findings to QAA committee. 5) Date of compliance is 07-22-23	

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pre/post treatment notes."

A review of the physician orders dated 4/24/23 revealed, "Resident receives Dialysis as follows: Tuesday, Thursday and Saturday with a 5:00 AM chair time. Diagnosis ESRD."

An interview was conducted on 6/7/23 at 9:30 AM with Resident #29. When asked if he takes his dialysis communication book to the dialysis center, Resident #29 stated, "Yes, the book goes with me. It is in the bag in my room."

A review of Resident #29's dialysis communication book revealed missing communication to the dialysis facility on 4/25/23, 4/27/23, 5/6/23, and 5/9/23.

An interview was conducted on 6/7/23 at 10:50 AM with RN (registered nurse) #1. When asked the purpose of the dialysis communication sheets, RN #1 stated, to provide communication about the resident's current condition, vital signs and maybe labs or medications. When asked if there is missing documentation, is the facility communicating with the dialysis center, RN #1 stated, "No, we would not be communicating on those days."

On 6/7/23 at approximately 1:35 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical services specialist was made aware of the findings.

A review of the dialysis contract dated 2012, revealed, "The nursing facility shall ensure that all appropriate medical and administrative information accompanies all ESRD residents at

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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 698	Continued From page 48 the time of transfer or referral to the ESRD Dialysis unit. This information, shall include, but is not limited to, where appropriate, the following: appropriate medical records, including history of ESRD resident's illness, laboratory and x-ray findings. Collaboration of care: The nursing facility shall ensure that there is documented evidence of collaboration of care and communication between the nursing facility and ESRD dialysis unit." No further information was provided prior to exit.	F 698		