STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/21/23 through 05/23/23. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.	E 039		6/28/23

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

Electronically Signed | 06/15/2023

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E 039	Continued From page 1 (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years,	E 039		

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E 039	Continued From page 2	E 039		

opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a

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narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant

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E 039	Continued From page 4	E 039		

emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency

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scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

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E 039	Continued From page 6 (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 7 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	E 039	E 039 Emergency Procedure Planning	

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E 039	Continued From page 9 review it was determined that the facility staff failed to have a complete emergency preparedness plan. The findings include: Facility staff failed to provide evidence of documentation of the facility's exercise analysis and response, and how the facility updated its emergency program based on the exercise analysis. On 5/23/23 at approximately 10:00 AM a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #3, the director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. OSM #3 stated that the facility did not have it. On 5/23/23 at approximately 2:00 PM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional vice president of operations, were made aware of the findings. On 5/23/23 at 4:00 PM, ASM #5 stated, we do not have the exercise analysis and response unless IT (information technology) can get me access to the previous administrator's hard drive to check there. No further information was obtained prior to exit.	E 039	1. The administrator conducted a table top emergency procedure drill and completed the after action report. The leadership staff participated in a community wide drill and submitted the after action report. 2. The administrator reviewed all the requirements for the Emergency Procedure Plans to verify completion. The location of the Emergency Drill Documentation Binder was reviewed with the Maintenance Director. 3. The Maintenance Director was educated by the administrator on the regulations concerning the annual required drills. He also attended the Central Virginia Health Care Coalition Community wide drill as a lead for the Farmville EPP team. 4. Table top drills will be scheduled quarterly and findings reported monthly x 3 at the QAPI meeting. The community will participate in the community wide drill each May on an annual basis.	

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F 000	Continued From page 10	F 000		
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 5/21/23 through 5/23/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

Nine complaints were investigated during the survey as follows (VA00058332-substantiated with no deficiency; VA00057689-substantiated with deficiency; VA00056675-substantiated with deficiency; VA00056603-substantiated no deficiency; VA00056463-substantiated with deficiency; VA00056356-substantiated no deficiency; VA00055793-substantiated no deficiency; VA00055634-substantiated with deficiency; VA00055239-substantiated with deficiency)

The census in this 120 certified bed facility was 94 at the time of the survey. The survey sample consisted of 34 current resident reviews and nine closed record reviews.

F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		6/28/23

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F 550	Continued From page 11 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to promote a resident's right to respect and dignity, for one of 43 residents in the survey sample, Resident #85. The findings include:	F 550	F 550 Resident Rights/Exercise of Rights 1. SS visited Resident #85 to verify he has been treated with respect and dignity during interactions with nurse practitioner. The Director of Nursing or designee will complete 1:1 education with the Nurse Practitioner on residents right to be treated with respect and dignity.	

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F 550	Continued From page 12 The facility staff failed to ensure Resident #85 was treated with respect and dignity during interactions with the nurse practitioner (NP). Resident #85 was admitted to the facility on 2/18/22 with diagnoses that include but are not limited to: traumatic spinal cord injury, neurogenic bladder, and quadriplegia. Resident #85's most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an assessment reference date of 5/9/23, 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 the facility grievance log revealed the following: "1/4/23: wants to speak to NP about medications, NP rushes past him and states she does not have time. 1/5/23 UM (unit manager) witnessed resident trying to stop NP and she told him "Not today" and she would see him the next day. Resident replied that she always tells him that. (UM spoke with resident about his concerns, resident reached out to state ombudsman)." A review of the NP (nurse practitioner) note dated 3/24/23 at 2:16 PM, revealed, "He continues to complain of spasticity, discussed that he was seen by MD (physician) on Monday and that this provider cannot see him on same days as MD." An interview was conducted on 5/21/23 at 2:45 PM with Resident #85. When asked about physician and NP coverage, Resident #85 stated, "It has gotten so much better in the last 4 weeks.	F 550	2. Any resident has the potential to be affected. SS and/or designee will interview interviewable residents to ensure they are being treated with respect and dignity by staff and medical providers. SS to contact non-interviewable residents responsible party to ensure they feel as if their loved one is treated with respect and dignity by staff and medical providers. 3. ADON or designee will educate 100% of staff, physician and nurse practitioner on resident rights to be treated with respect and dignity. Education will be included on new hire orientation. 4. SS or designee will complete 5 random interviews with interviewable residents and 1 non-interviewable residents responsible party weekly x 4 weeks then monthly x2 months to ensure resident rights including but not limited to being treated with respect and dignity are being honored. The Administrator or designee will review audit findings and submit report to the QAPI committee monthly x3 months for any further recommendations.	

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F 550	Continued From page 13	F 550		

The physician sees me twice a week. He communicates well with me. The nurse practitioner does not see me regularly. I complained to the unit manager and the previous administrator about the NP brushing me off." When asked how it made them feel, Resident #85 stated, "I feel dismissed and not respected when I just want to ask her for clarification and ask some questions, sometimes it was about appointments."

An interview was conducted on 5/23/23 at approximately 9:00 AM with ASM (administrative staff member) #4, the nurse practitioner. When asked about the interactions with Resident #85, ASM #4 stated, "He wants to stop me and ask me questions when he has already seen the physician. I have told him that I cannot see him that day, that he will have to wait till the next day. Why did he not ask the physicians those questions?" When asked what questions he would ask, ASM #4 stated, "Sometimes about medications or appointments." When asked what actions she takes when Resident #85 asks her questions and she does not see him, ASM #4 stated, "Well I see him the next day. Only one of us can see him per day." When asked if it was due to billing, ASM #4 did not respond. When asked what actions are taken to communicate and collaborate with the physician if she does not see the physician, ASM #4 stated, she talked with the physician about concerns voiced, but when asked if she documents that in a progress note, ASM #4 stated, no, not usually.

On 5/23/23 at approximately 2:00 PM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional vice

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F 550	Continued From page 14 president of operations, were made aware of the findings. No further information was provided prior to exit.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility	F 561	F561 Self-Determination	6/28/23

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F 561	Continued From page 15 document review, the facility staff failed to promote resident choice of eating venue, for one of three meals, the dinner meal. The findings include: The facility staff failed to offer residents the choice to eat dinner in the dining room. The facility dinner time was documented as 5:00 p.m. On 5/21/23 at 5:15 p.m., observation of the dining room was conducted. No residents were observed in the dining room. On 5/22/23, breakfast and lunch were observed to be served in the dining room. The staff carried plates of food on trays from the kitchen into the dining room. On 5/22/23 at 11:35 a.m., an interview was conducted with OSM (other staff member) #6, the dietary manager. OSM #6 stated she was employed at the facility since 5/9/23 and dinner has not been served in the dining room since she began employment. OSM #6 stated a new steam table was ordered before she began employment, and she was waiting on the steam table to arrive. OSM #6 stated breakfast and lunch were being served in the dining room, but she did not have an explanation why dinner was not being served in the dining room. On 5/22/23 at 1:07 p.m., an interview was conducted with ASM (administrative staff member) #2, the regional vice president of operations. ASM #2 stated he was not aware dinner was not being served in the dining room and something could be done to provide dinner in the dining room. The administrator was not available for interview during the survey.	F 561	1. The Regional Director of Clinical Services educated the Director of Nursing and Dietary Manager on resident rights to choose eating venue for all three meals. 2. Any resident has the potential for be affected. An audit of residents will be completed to verify who wishes to eat in the Dining Room for the evening meal and dining room will be open for all three meals to promote their choice of eating venue. 3. ADON or designee will educate 100% staff on resident□s right for choice of eating venue. Education will be included on new hire orientation. 4. Dietary manager or designee will complete 5 random interviews weekly x4 and monthly x2 to ensure residents are being offered the choice to eat meals in the dining room. The Administrator or designee will review audit findings and submit report to QAPI committee monthly x3 for any further recommendations.	

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F 561	Continued From page 16 On 5/23/23 at 2:37 p.m., ASM #1, the director of nursing, and ASM #2 were made aware of the above concern. The facility policy titled, "Dining Experience at Mealtimes Policy" documented, "Staff will encourage residents to eat in the dining areas and encourage and assist them to consume food and beverages."	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		6/28/23

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F 583	Continued From page 17 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide personal privacy for one of 43 residents in the survey sample, Resident #349. The findings include: For Resident #349 (R349), the facility failed to offer interventions to prevent other residents from wandering into R349's room. The MDS (minimum data set) assessment was not due at the time of the survey. On the admission nursing assessment dated 5/13/2023 R349 was assessed as being alert and oriented to person, place, time and situation. The resident was assessed as having a speech impairment, as speaking in a whisper voice, requiring two person assistance for bed mobility, dressing, eating, transfers and toileting. On 5/21/2023 at 2:54 p.m., an interview was conducted with R349 in their room. R349 stated that they were new to the facility and had two residents wander into their room on different occasions. R349 stated that once they were in the bathroom and a woman wandered in and tried	F 583	F583 Personal Privacy/Confidentiality of Records 1. Resident #349 no longer resides in the center. 2. Any resident has the potential to be affected by other residents who may wander into their rooms. Social Service Director (SS) or designee will interview interviewable residents to ensure their right of privacy is protected. SS to contact non interviewable resident□s Responsible Party to ensure their right of privacy is protected. Any resident expressing concern with others wandering into their room will be offered interventions to prevent the wandering. 3. ADON or designee will educate 100% of staff on resident□s right to have privacy protected including but not limited to other residents wandering into their rooms. Education will be included on new hire orientation. 4. SS or designee will conduct 5 random interviews with interviewable residents and 1 non-interviewable residents responsible party weeklyx4 monthly x2 to ensure resident right of privacy being protected. Administrator or designee will review audit findings and submit report to	

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F 583	Continued From page 18 to get into the bathroom. R349 stated that their husband was visiting and had gotten a staff member to come get the resident. R349 stated that on another occasion a male resident had wandered into their room and gone into their bathroom so they had put their call light on and gotten the attention of a staff member to get them out. R349 stated that the residents could not hear her asking them to leave because their voice was so weak and they did not bother anything they were just confused. R349 stated that the staff had removed the residents. R349 stated that they had started keeping their door closed to keep the residents out but had asked the staff to keep the residents out of their room because they were bed bound and could not get the residents out by themselves. When asked if staff had offered any interventions to prevent residents from wandering in their room, R349 stated, "No." Observations conducted during the survey dates revealed R349's door remained closed each day, no residents were observed entering the room. Residents were observed being redirected by staff to their rooms or to activities when observed wandering in the hallways of the facility or near exit doors. On 05/22/2023 at 12:16 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that they had a few residents who were confused and wandered. CNA #5 stated that they tried to redirect them to an activity or to the alcove where there were televisions. CNA #5 stated that when residents wandered into the wrong room they tried to redirect them out of the room. CNA #5 stated that they were not aware of any interventions for residents who did not want wandering residents coming into their	F 583	QAPI committee monthly x3 for any further recommendations.	

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F 583	Continued From page 19	F 583		

rooms.

On 5/22/2023 at 4:35 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that wandering residents were redirected them out of any rooms they may wander into. LPN #5 stated that they walked the residents who wandered around more. LPN #5 stated that they were not aware of any interventions for residents who did not want wandering residents coming into their rooms. LPN #5 stated that they were aware of stop signs that could be placed on the doors but they did not use them at the facility.

On 5/23/2023 at 9:39 a.m., an interview was conducted with LPN #4, unit manager. LPN #4 stated that kept an eye on residents that wandered the best that they could. LPN #4 stated that if residents alerted them that a resident had wandered into their room that they were able to intervene. LPN #4 stated that they did not use any other interventions to keep the residents from wandering into other residents rooms and they were not aware of R349 having the two residents come into their room.

On 5/23/2023 at approximately 2:45 p.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that activities tried to do diversionary activities and redirection for wandering residents. RN #2 stated that redirection was the best thing but there were still going to be some wanderers. RN #2 stated that they tried to put different interventions in place like activities, extra staff, and sometimes they did one to one. RN #2 stated that normally there were no issues and the residents could be redirected. RN #2 stated that they were not

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F 583	Continued From page 20 aware R349 having any residents wandering into their room. The facility policy, "Resident Rights and Facility Responsibilities" revised 9/3/2020 documented in part, "It is the facility's policy to comply with all Residents Rights, and to communicate these rights to residents and their designated representatives in a language that they can understand..." On 5/23/2023 at 1:54 p.m., ASM (administrative staff member) #1, mobile director of nursing, ASM #2, regional vice president of operations and ASM #5, divisional vice president of operations were made aware of the concern. No further information was provided prior to exit.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		6/28/23

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F 584	Continued From page 21 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. 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 maintain a clean, comfortable, homelike environment for three of 43 residents in the survey sample, Residents #3, #6 and #31. The findings include: 1. For Resident #3 (R3), the facility staff failed to maintain the resident's wheelchair in good repair. The vinyl covering on both armrests was torn with foam exposed. On 5/21/23 at 2:15 p.m., R3 was observed sitting	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. Resident #3□s wheelchair armrests have been replaced. Resident #6□s wall behind the resident□s bed has been repaired. Resident #31 PTAC unit has been cleaned. 2. Any resident has the potential to be affected. The Director of Maintenance or designee will conduct 100% room rounds to verify all PTAC units are clean, wheelchair armrests and walls in good condition. 3. The ADON or designee will educate 100% staff on the facility□s process of	

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F 584	Continued From page 22 in a wheelchair. On the right armrest, a section (approximately 12 inches in length by 0.5 inches in width) of the vinyl covering was torn with foam exposed. On the left armrest, a section (approximately four inches in length by 0.5 inches in width) of the vinyl covering was torn with foam exposed. Approximately four inches at the end of the arm rest was wrapped in medical tape. On 5/22/23 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that usually the therapy department handles the repair or replacement of wheelchair armrests, but the nursing staff will report to the therapy staff if they see an armrest that needs to be fixed. On 5/22/23 at 3:58 p.m., an interview was conducted with OSM (other staff member) #7, the occupational therapist. OSM #7 stated that he, the director of rehab, and the physical therapist are all over the building so they usually identify wheelchair armrests that are in need of repair, but staff or residents can report armrests in need of repair then the therapy staff will address them. On 5/23/23 at 10:45 a.m., an interview was conducted with LPN #4. LPN #4 stated the nursing staff reports torn wheelchair armrests to the therapy staff. LPN #4 stated torn wheelchair armrests are not clean, comfortable or homelike. On 5/23/23 at 2:37 p.m., ASM (administrative staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern. The facility policy titled, "Personal Belongings Policy" documented, "2. The resident is	F 584	notification to Maintenance/Housekeeping on any environmental concerns included but not limited to cleanliness of PTAC units, damaged walls and wheelchair armrests needing repair etc. Education will be included on new hire orientation. 4. The Director of Maintenance or designee will conduct 5 random room checks weekly x4, then monthly x2 to verify but not limited to PTAC units are clean, walls and armrests are in good repair. Administrator or designee will review audit findings and submit report to QAPI committee monthly x3 months for any further recommendations	

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F 584	Continued From page 23	F 584		

encouraged to maintain his/her room in a home-like environment..."

2. For Resident #6 (R6), the facility staff failed to maintain the wall behind the resident's bed in good repair.

Observation was made of R6's room on 5/21/2023 at approximately 1:30 p.m. There were multiple linear deep gouges on the wall behind the bed.

On 5/22/2023 at 10:07 a.m. OSM (other staff member) # 3, the maintenance director, was shown the wall behind R6's bed. OSM #3 was asked if the wall is homelike, OSM #3 responded, no. When asked how things are brought to his attention that need repair, OSM #3 stated there is a book on each unit to write things that need repair. Residents will stop him and tell him what needs to be repaired and he gets text messages from the staff of things that are more urgent to be repaired. OSM #3 stated he has only been at the facility for two weeks and is focusing on the repairs that are safety concerns first.

ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m.

No further information was provided prior to exit.
3. For Resident #31, the facility staff failed to maintain the PTAC unit (packaged terminal air conditioner unit) in a clean and sanitary manner. A PTAC is a type of self-contained heating and air conditioning system.

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On the most recent MDS (Minimum Data Set), an annual assessment dated 2/19/23, Resident #31 was coded as being cognitively intact in ability to make daily life decisions.

On 5/21/23 at 2:52 PM, in an interview with Resident #31, they stated that their PTAC unit was dirty and had not been cleaned in a while and was causing them breathing problems (the resident was noted to be on 3 liters of oxygen). The unit was observed to have dust and lint build up coming out of the vents on the front of the unit. The resident stated there is not a routine for cleaning it, that it only gets cleaned when they complain about it.

On 5/22/23 at 8:59 AM and 2:17 PM, the PTAC unit was observed to be in the same condition as above.

On 5/22/23 at 2:10 PM an interview was conducted with OSM #3, the maintenance director. He stated that he has been at the facility for two weeks, and has not gotten to checking PTAC units yet and would check resident's unit. He stated he has not been notified by staff or resident that there was any issue with the PTAC unit.

On 5/23/23 at 1:35 PM an interview was conducted with OSM #18, a housekeeping aide. She stated that she cleans the units when she sees they need it. She stated that it was not a set routine. She stated that maintenance takes care of them but she will clean the top and front when needed. When asked about Resident #31's unit, she stated she last cleaned it a couple weeks ago, but that was "because (Resident #31) had

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F 584	Continued From page 25 been complaining about it." The facility policy "General/Routine Environmental Cleaning and Disinfection Policy" was reviewed. This policy documented, "E. Horizontal surfaces with infrequent hand contact (e.g., windowsills and hard-surface flooring) in routine patient care areas require cleaning on a regular basis, when soiling or spills occur, and when a patient is discharged from the facility. Housekeeping/Environmental Services sets cleaning and disinfecting schedules in conjunction with needed recommendations from the facility Infection Preventionist." On 5/23/23 at 1:54 PM, ASM #1 (Administrative Staff Member) the Director of Nursing, ASM #2 the Regional Vice President of Operations and ASM #3 the Divisional Vice President of Operations, were made aware of the findings. No further information was provided.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		

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F 600	Continued From page 26 involuntary seclusion; 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 ensure that one of 43 residents in the survey sample was free from resident-to-resident abuse, Resident #29, which resulted in harm cited at past non-compliance. The findings include: Resident #103 intentionally pushed Resident #29, which resulted in a fall with a shoulder fracture for Resident #29. Resident #103 had documented behaviors and that the resident required increased supervision. There was no evidence that increased supervision was provided at the time of the occurrence. The facility abuse policy read: "Abuse, Neglect and Exploitation" documented, "This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone....Definitions: Abuse - Includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish....Physical Abuse - includes hitting, slapping, pinching and kicking....Verbal abuse - is defined as the use of oral, written or gestured language that willfully includes...threats of harm..." A review of the facility synopsis of the event that occurred on 2/2/23 revealed the following: A witness statement documented that the hospice chaplain spoke with (Resident #103) and stated	F 600	Past noncompliance: no plan of correction required.	

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that the resident "believes this is [their] home and all of these residents are trespassing. (Resident #103) was talking on [their] phone and (Resident #29) told (Resident #103) to get off the [profanity] floor. (Resident #103) felt disrespected and told (Resident #29) if [they are] going to talk to (Resident #103) like the floor [sic] (Resident #29) would end up on the floor."

Another witness statement documented a statement made by Resident #29 "....(Resident #103) pushed me and I fell."

A review of the "Petition for Involuntary Admission for Treatment" dated 2/2/23 documented, "Resident exhibiting physical aggression. Pushed (Resident #29) down and broke [their] left shoulder...(Resident #103) felt disrespected and told (Resident #29) if (Resident #29) is going to talk to (Resident #1030 like the floor (Resident #29) would end up on the floor...."

Resident #29 had diagnoses of but not limited to, brain cancer, psychosis, epilepsy, femur fracture, wedge compression fracture of thoracic vertebra and glaucoma. The most recent MDS was a quarterly assessment dated 3/17/23. The resident was coded as being impaired with ability to make daily life decisions, scoring a 11 out of a possible 15 on the BIMS. The resident required supervision to limited assistance for all areas of activities of daily living except for bathing which was extensive assistance.

A review of the clinical record for Resident #29 revealed the following:

A nurse's note dated 2/2/23 documented, "This note is a follow up to Fall secondary to resident

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assault...Evidence of pain noted Left shoulder/bilateral knees Pain is throbbing Pain is sharp Pain level is 8 out of 10. The pain is constant Pain is persistent daily. Guarding left shoulder to chest and bilateral knees..."

A nurse's note dated 2/2/23 documented, "...Resident is Cooperative. Resident is Tearful. Range of motion deficits are Left Shoulder limited ROM any movement about chest she screams out in pain....Evidence of pain noted Left Shoulder and Bilateral Knees Pain is throbbing Pain is sharp Pain level is 7 out of 10. The pain is intermittent Pain is persistent daily. Guarding Left Shoulder to chest. Non ambulation due to knee discomfort.

A nurse practitioner note dated 2/2/23 documented, "...Pt (patient) was seen, reports that another resident pushed [them] and [they] fell. [Resident] is c/o (complaining of) mainly of left shoulder pain, but states that [they] landed on [their] knees then shoulder. No contact to head with floor. [Resident] is crying and c/o pain. [Resident] is unable to AROM (active range of motion) left arm at shoulder. Gently moved left arm PROM (passive range of motion) approximate 10 degree abduction with pt screaming in pain. [Resident] c/o pain on palpation of shoulder at glenohumeral joint. Discussed with staff, and will send pt to ER for evaluation as there appears to be joint compromise..."

A nurse's note dated 2/2/23 documented, "Resident returned to Facility via stretcher accompanied by 2 EMS (emergency medical services) providers. Resident has sling to left shoulder/arm...Er discharge instructions as

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follows: Diagnosis Fracture of proximal end of left humerus, fall, alleged assault and knee contusion..."

Resident #103 had documented behaviors. The facility staff documented evidence that the resident required increased supervision. There was no evidence that increased supervision was provided at the time of the resident-to-resident altercation.

Resident #103 had the diagnoses of but not limited to cancer of the prostate and bone and dementia. The most recent MDS (Minimum Data Set) was a significant change MDS dated 12/19/22. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status). The resident was coded as requiring supervision only for eating, toileting and hygiene; and was coded as being completely independent for all other areas of activities of daily living. The resident was coded as having physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others. The resident was coded as behavior symptoms significantly interfered with the resident's ability to participate in activities and social interactions. The resident's behavior symptoms were coded as putting others at significant risk of physical injury. The resident's behavior was coded as being worse since the prior MDS assessment (Admission assessment dated 11/28/22 wherein the resident was coded as having delusions and wandering behaviors).

A review of the clinical record for Resident #103 revealed the following notes:

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A social worker note dated 12/1/22 documented, "...Charge Nurse also reported behaviors of vulgar language and comments to "shoot their kneecaps off" if [resident] wasn't allowed to go home..."

A nurse practitioner note dated 12/1/22 documented, "...Staff report that [resident] often is wandering the facility and is sometimes not always easily redirected....1. Dementia with behaviors: Noted mild agitation and behaviors..."

A nurse's note dated 12/7/22 documented, "...Resident becoming aggressive towards staff. Resident makes statements about hurting staff."

A nurse practitioner note dated 12/27/22 documented, "...Recently cane was removed from [resident] possession because of reports of striking out with cane...1. Dementia with behaviors: Noted mild agitation and behaviors, Continue sertraline (1), olanzapine (2), donepezil (3), memantine (4). Followed by psychology, continue with recommendations. Recent walking cane removal r/t (related to) aggressive behaviors per staff...."

A nurse's note dated 1/7/23 documented, "Resident was aggressive towards writer at the beginning of the shift. Resident pushed [their] walker towards writer to try and run writer over, [resident] then picked [their] walker up from the floor and again came towards this writer to try and hit again. [Resident] had displayed exit seeking behaviors, such as going to the door that lead to outside and has been trying to get out and find [their] truck. This writer redirected [resident] and informed [resident] [they] [do] not have truck

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outside. Hospice was called at 1040am and made aware, however, I am waiting on a call back from the nurse at this time. Activity staff is currently sitting one to one with resident because of exit seeking behavior. Will cont (continue) to monitor and document. RP (responsible party - resident family member) made aware."

A nurse's note dated 1/7/23 documented, "Hospice in to see resident at 1209 pm. Nurse spoke with resident. 2 (two) new orders in for resident. Since lunch [resident] has been pleasant. One to one aide has been with [resident] in close range..."

A nurse's note dated 1/15/23 documented, "Aide overheard resident yelling from her room, yelling get out, aide noted resident from room (number) coming out of resident room, Aide redirected resident back into room and notified Writer, Writer went to talk to resident, resident says that resident came into the room and I told [Resident #103] no get out, resident continue to walk toward the bed and touch my foot then walked out of room..."

A physician's note dated 1/16/23 documented, "...exhibits advanced confusion, with nonsensical speech and disorientation. Has been wandering aimlessly into other residents' rooms in past three weeks..."

A nurse practitioner note dated 1/18/23 documented, "Staff concerned over pt (patient) continually wandering, slightly unsteady on [their] feet. [Resident] has been moved closer to nurses station..."

A social worker note dated 1/20/23 documented,

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"Resident reviewed in IDT (interdisciplinary team) meeting due to behaviors. Resident is often verbally aggressive with staff and wandering into the rooms of other residents after being redirected and not wanting others to use ["Resident #103"] bathroom. Resident is often restless and has to be re-directed from trying to leave the facility. Resident has been moved to another room with a private bathroom. Resident will continue to be monitored and redirected as needed."

A nurse's note dated 1/27/23 documented. "Resident wandering in/out of multiple residents rooms. Res (resident) not redirectable. Resident went into room (number) with pants down. Residents in (room) scared, and stated they will call the cops if this keeps happening."

A nurse's note dated 1/27/23 documented, "...Unit Manager called Hospice (company) and spoke with Case manager (name) and asked for 1-1 sitter to help keep patient directed to prevent any further incidents which would avoid the police/ At this time hospice has no extra help or able to provide 1/1 and advised if redirecting does not work to send [resident] to ER [emergency room]..."

A nurse's note dated 2/1/23 documented, "Resident sitting in hallway, on wheeled walker, yelling "HELP" when approached about whats wrong resident stated [they] wanted a back scratcher. When resident realized I did not have one [they] became verbally aggressive, called this nurse "A stupid ugly [profanity]" Resident then grabbed walker like [they] was going to throw it at this nurse, resident then proceeded to use verbal slurs. Resident able to be directed back towards

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room after several minutes of coaxing. PRN medications administered to no avail. Spoke with Hospice. New orders implemented for agitation."

A nurse's note dated 2/2/23 documented, "Unit Manager was gotten out of Morning meeting from charge Nurse and reported that Resident had assaulted a female Resident and pushed her to the floor and the NP (nurse practitioner) was on the unit and is in with [other] resident and asking for [resident] to be sent out to the Emergency Room due to possible Fracture of left shoulder."

A nurse's note dated 2/2/23 documented, "Summary of Discharge: Resident Discharged To: Resident ECO'd (emergency confinement order). Discharged via: Ambulatory....Accompanied by (local) Sheriff Department....Social Service Summary: Resident was involved in an incident where [they] pushed a [another] resident and [other resident] fell and was injured. DON and SW went to the (county) Sheriff Dept to file an ECO and (county) Law Enforcement arrive at the facility around 7pm to pick resident up....Resident's [family member]/emergency contact was contacted...."

A nurse's note dated 2/3/23 documented, "This writer called ER to follow up on resident. RN (Registered Nurse) (name) at (hospital) stated [Resident #103] is still in the ER and they are waiting on bed placement. They are seeking bed placement for Psychiatric care."

A nurse's note dated 2/3/23 documented, "Resident to resident incident 2/2/23....Resident initiated physical aggression on female peer. [Resident #103] was provided one to one care until an ECO could be obtained. [County]

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deputies transported resident to ER for evaluation of psychiatric services. Per report from (hospital) resident being sent to [psychiatric] Hospital for psychiatric stabilization. MD, Hospice, and family aware."

A review of the comprehensive care plan for Resident #103 revealed one dated 11/30/22 for "Resident is on antipsychotic therapy..." This care plan was updated on 12/7/22 to include, "verbally abusive and threatening towards staff."

Another care plan, dated 1/10/23, documented, "Resident shows behaviors by....goes into other residents rooms and lying in their beds." This was updated on 1/23/23 to include "Resident with episode of nudeness in the hallway."

The above care plans did not include any interventions for the provision of supervision or the need of increased supervision related to wandering, behaviors, and aggression.

Interviews:

On 5/22/23 at 4:44 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that "If we didn't have [Resident #103] on 1:1 we didn't have the staff [to provide 1:1]. The only thing was to redirect him. Sometimes it was not effective." When asked about Resident #103's aggressive behaviors, she stated, "It's a red flag he could be aggressive to other residents." And stated a 1:1 could have kept the resident from being able to hit someone else and could have separated him from others if he was becoming aggressive.

On 5/23/23 at 10:58 AM an interview was

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conducted with RN #2 (Registered Nurse). She stated that the resident required increased supervision and that "I would assign 1:1." She stated that it was her recommendation during a meeting to move Resident #103 and to provide 1:1. She stated that the facility called hospice for 1:1. She stated that it was not their [hospice] responsibility to but it was due to [facility] staffing. She stated that there should have been other interventions in place.

On 5/23/23 at 12:30 PM an interview was conducted with the Director of Nursing (ASM-administrative staff member #1), who was not employed at the facility at the time of the incident; and ASM #3, the Regional Clinical Consultant. When asked about Resident #103's increase in behaviors of aggression and wandering in other residents rooms to the point that other residents threatened to call the cops if it did not stop, and that on 1/27/23 the facility even called hospice to provide a 1:1 sitter, why didn't the facility provide increased supervision or place the resident on 1:1 with facility staff, ASM #3 stated the staff would "keep an eye on (Resident #103) more on days the resident wandered." When asked if the interventions were effective, ASM #1 stated they were not. The facility was unable to evidence that with the increase in aggression, behaviors and wandering that Resident #103 was provided with any increased supervision which resulted in a resident-to-resident abuse with injury.

On 5/23/23 at 4:01 PM, in a follow up interview with ASM #3, when asked if Resident #29 was free from abuse, she stated, "I would have to say that she wasn't."

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On 5/22/23 at 5:17 PM, ASM #1, ASM #2 (Regional Vice President of Operations), ASM #3, and ASM #5 (Divisional Vice President of Operations) were made aware of the concern for harm.

A review of facility documentation evidenced the components of a plan of correction with a compliance date of 2/2/23 as described below:
1. Resident #103 was removed from the facility and more appropriate placement was arranged elsewhere.
2. The facility did a 100% audit of all residents for aggressive and wandering behaviors.
3. The facility did a 100% audit of all residents for evidence of abuse, that included skin checks.
4. The facility did a 100% education of all staff of the abuse policy "Abuse, Neglect and Exploitation."
5. The facility completed weekly round audits of all residents to identify and address any concerns any residents had.

This deficiency is cited at past non-compliance.

References:
(1) Sertraline is an antidepressant used to treat depression, obsessive-compulsive disorder, panic attacks, post traumatic stress disorder, and social anxiety disorder.
Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html

(2) Olanzapine is an atypical antipsychotic used to treat schizophrenia
Information obtained from https://medlineplus.gov/druginfo/meds/a601213.html

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FARMVILLE HEALTH & REHAB CENTER	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(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 600	Continued From page 37 (3) Donepezil is used to treat dementia. Information obtained from https://medlineplus.gov/druginfo/meds/a697032.html (4) Memantine is used to treat Alzheimer's disease. Information obtained from https://medlineplus.gov/druginfo/meds/a604006.html (4) Ativan is used to treat anxiety and insomnia caused by anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		

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F 609	Continued From page 38 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 report an injury of unknown origin in a timely manner for one of 43 residents in the survey sample, Resident #149. This is cited at past non-compliance. The findings include: For Resident #149 (R149), the CNA (certified nursing assistant) failed to report to the nurse, a bruise on R149's face in a timely manner. A facility synopsis of event with an injury of unknown origin was sent to the State Agency on 10/25/2022. The synopsis documented in part, "On 10/25/2022 during afternoon rounds, DON (director of nursing) noted a hematoma to the forehead. No falls had been reported. The resident is under hospice care at this time. An investigation is underway and outcome to follow." The facility synopsis of the event dated 11/1/2022, documented, "An investigation was launched. Upon interviewing staff and roommate, it was discovered that on the previous night (10/24/2022) the resident had been assisted back to bed by staff using a Hoyer lift. The staff	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 39	F 609		

accidentally bumped into a chair in the room while transferring, which is when resident potentially bumped her head on the lift. Staff present did not note any injury, and thus did not report incident until interviewed. MD (medical doctor) and RP (responsible party) made aware."

The written witness statement dated, 10/24/22, from CNA #14 documented, "I, (CNA #14) was (149)'s CNA on 10/24/22. There wasn't any opening skin on her during 3:00 - 11:00 p.m. I did assist resident back to be (sic) using Hoyer lift back to bed, during transfer lift bumped into a chair in the room, I am unaware if at that time [they] may have bumper her head on the lift, I did not notice any injuries to the patient at that time." CNA #14 was not available for interview during the survey.

The written witness statement dated, 10/25/22, from CNA #7, documented, "Upon entering (R149)'s room to feed her breakfast, I was cleaning (their) face and when (they) turned (their) head, I noticed the spot on (their) left eye."

The written witness statement dated, 10/25/2022, from ASM (administrative staff member) #6, the former director of nursing, documented in part, "While doing my rounds prior to leaving for the day, (LPN - licensed practical nurse #4) alerted me that the family of (R149) had a concern. When they came in to visit (R149), they noted that she had a hematoma above (their) left eyebrow. I immediately went to see (R149) and also note that (they) did indeed have a hematoma above (their) left eyebrow. In addition to the hematoma (R149) was noted to have bruising to left eyelid and just slightly under (their) left eye. Family expressed wishes for (R149) to be sent

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out to have 'x-ray' done of (their) face. (R149)'s daughter and son that were present at the bedside stated that resident did not have 'that' yesterday evening when they had visited. The son stated, 'it had to have happened on, what is it, 11-7 or today'... (CNA #7) was assigned the resident on 7-3 pm Tuesday October 25th. She reported that she noted the hematoma on resident during her morning AM care when she was washing her face. She reported that she did not see it at first until (R149) turned (their) head. I asked her if she reported the area to anyone and she stated, 'I just assumed that (R149) had a fall or something and that ya'll knew about it."

An interview was conducted with CNA #7 on 5/23/2023 at 11:10 a.m. The above statement made by her was reviewed. When asked if she notices a bruise or anything unusual for the resident she is caring for, what action should she take, CNA #7 stated she has to tell the nurse right away.

The facility policy, "Virginia Resident Abuse Policy," documented in part, "Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy...Injury of Unknown Source. An injury is classified as an "Injury of Unknown Source" when both the following conditions are met:
a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; AND b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries

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observed at one particular point in time, or the incidence of injuries over time.... Prevention & Identification:.. i. The identification of events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation... 4) Protect the Resident: If the resident is injured. If the resident is injured as a result of the alleged or suspected incident, the Facility should take immediate* action to treat the resident. a. Staff should report all incidents immediately to their direct supervisors."

The following information was provided as evidence of a plan of correction:
1. The identification of the abuse policy regarding reporting immediately any bruise or injury of unknown origin and the use of the Hoyer lift.
2. The education was provided with a list of all staff trained in abuse and the use of the Hoyer lift.
3. Audit were reviewed for the use of the Hoyer lift. No concerns were noted.
4. Their date of compliance was 1/23/2023.

During the survey process there were no concerns identified related to abuse reporting or use of the Hoyer lift.

ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m.

No further information was provided prior to exit.

Past non-compliance.

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		6/28/23

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized 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

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F 656	Continued From page 43 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, facility document review, and clinical record review, the facility staff failed to implement the care plan for four of 43 residents in the survey sample, Residents #57, #85, #31, and #10. The findings include: 1a. For Resident #57 (R57) the facility staff failed to follow the care plan for diabetes. R57 was admitted to the facility with a diagnosis of diabetes mellitus (1). A review of R57's physician orders revealed the following order dated 9/8/22: "Trulicity (2) Solution Pen-injector 1.5 MG/0.5ML (Dulaglutide). Inject 1.5 mg subcutaneously week every Fri related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY (E11.42)." A review of R57's MAR (medication administration record) for September 2022 revealed R57 received two doses of Trulicity on 9/9/22. A review of R57's progress notes revealed the following:	F 656	F656 Develop/Implement Comprehensive Care Plan 1. 1.a Resident #57□s Medication Administration Record (MAR)and care plan for diabetes has been reviewed to verify care plan has been implemented per the care plan. 1.b Resident #57□s care plan has been reviewed and resident interviewed by Unit Manager to verify she has received meals per physician orders and free of known allergies per care plan. Resident #85□s ADL records specifically for incontinence care have been reviewed for June and resident interviewed to verify his needs are being met and care plan for ADLs is being followed. Resident #31□s MAR for past 7 days to verify pain mend has been administered per physician order and per care plan. The nurse caring for Resident #10 who administered bedtime dose of Trazodone during morning med pass has been educated, the nurse practitioner was notified that resident received wrong dose administered, no negative clinical outcome observed. 2. Any resident can be affected. The	

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F 656	Continued From page 44 "9/9/22 8:26 p.m. Writer was phoned about resident receiving an extra dose of Trulicity. Writer spoke with both daughters about this. Writer informed them resident will be assessed and monitored. Writer in to assess resident. Skin warm and dry. In bed with HOB elevated on phone talking with her daughter ...Blood sugar taken -197. Writer phoned on-call and spoke with Dr. March to inform of listings. New orders obtained to increase blood sugars to ac (with meals) and hs (at bedtime) x 7 days. Glucagon was added to med orders. At present, resident alert and verbal. She is responding in usual fashion." A review of R57's care plan dated 11/26/21 revealed, in part: "Resident is at risk for hypo/hyperglycemia episodes R/T: diabetes ...administer medications as ordered." On 5/22/23 at 3:34 p.m., RN (registered nurse) #2, the MDS (minimum data set) coordinator, was interviewed. She stated the care plan is "what we go by to care for our residents." She stated that the entire facility staff is responsible for making sure the care plan is implemented for every resident. On 5/23/23 at 2:25 p.m., ASM (administrative staff member) #2, the regional vice president of operations, ASM #3, the regional clinical consultant, and ASM #1, the mobile director of nursing, were informed of these concerns. A review of the facility policy, "Interim/Baseline Care Planning Policy," revealed no information related to implementing the comprehensive care plan.	F 656	MDS or designee will review residents care plans to ensure care plans are being implemented including but not limited to management of diabetes, depression/anxiety and pain, ADLs and allergies. 3. DON or designee will educate 100% staff on purpose and implementation of care plans to ensure care plans are being followed to address resident needs. Education will be included on new hire orientation. 4. MDS or designee will review 5 residents weekly x4 then monthly x2 to verify care plans interventions implemented. Director of Nursing or designee will review audit findings and submit report to QAPI committee monthly x3 for any further recommendations.	

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No further information was provided prior to exit.

NOTES
(1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(2) "Dulaglutide (Trulicity) injection is used with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a614047.html

1.b. For R57, the facility staff failed to follow the care plan for allergies.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/17/23, R57 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

On 5/22/23 at 1:02 p.m., R57 was observed sitting up in bed. The lunch tray was open on the overbed table next to the resident. The lunch plate contained pulled pork and pork and beans. R57 stated she cannot eat either the pork or the pork and beans because of the Alpha-Gal (1) allergy. The resident stated she cannot have beef or pork products, but the facility serves them to her "all the time." R57 shared the meal ticket that accompanied the lunch tray. A review of the meal ticket revealed: "Allergies: Beef, Pork."

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A review of R57's physician orders revealed the following order dated 4/13/22: "Regular diet, Regular texture, Thin consistency, for diet NO BEEF, PORK or Dairy Products."

A review of R57's diagnoses revealed: "7/21/22 Allergy Avoid all o Mammalian Meats."

A review of R57's care plan dated 9/22/22 revealed, in part: "Avoid all mammalian meats."

On 5/22/23 at 1:17 p.m., OSM (other staff member) #6, the dietary manager, was interviewed. She stated the facility's EMR (electronic medical record) software generates the meal ticket for each resident, and includes food allergies. She stated the cook who serves the plate is responsible for making sure the resident is not allergic to any of the food on the tray. She stated residents with an Alpha Gal allergy should not receive any pork or beef. She stated she had not been at the facility long enough to know if any current residents have this allergy. When informed of R57's Alpha Gall allergy, she stated the resident should not have received pork and beans and pulled pork on the lunch tray.

On 5/22/23 at 3:34 p.m., RN (registered nurse) #2, the MDS (minimum data set) coordinator, was interviewed. She stated the care plan is "what we go by to care for our residents." She stated that the entire facility staff is responsible for making sure the care plan is implemented for every resident.

On 5/23/23 at 2:25 p.m., ASM (administrative staff member) #2, the regional vice president of

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operations, ASM #3, the regional clinical consultant, and ASM #1, the mobile director of nursing, were informed of these concerns.

No further information was provided prior to exit.

NOTES
(1) "Alpha-gal syndrome is a type of food allergy. It makes people allergic to red meat and other products made from mammals." This information is taken from the website https://www.mayoclinic.org/diseases-conditions/alpha-gal-syndrome/symptoms-causes/syc-20428608#:~:text=Alpha%2Dgal%20syndrome%20is%20a,alpha%2Dgal%20into%20the%20body.
2. For Resident #85, the facility staff failed to implement the comprehensive care plan for ADL (activities of daily living) care.

Resident #85 was admitted to the facility on 2/18/22 with diagnoses that included but not limited to: traumatic spinal cord injury, neurogenic bladder, quadriplegia and hypertension.

Resident #85's most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an assessment reference date of 5/9/23, 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. MDS Section G- Functional Status: coded the resident as total dependence with bed mobility, transfers, dressing, eating, hygiene and bathing. Walking did not occur. Locomotion is supervised in motorized wheelchair. A review of MDS Section H- Bowel and Bladder: coded the resident as external catheter for bladder and frequently incontinent for bowel.

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A review of the comprehensive care plan dated 11/1/22 documented in part, "At risk for constipation/dehydration related to decreased mobility, weakness and history of constipation and quadriplegia. Resident has skin breakdown related to: decreased mobility, weakness, Quadriplegia and history of dermatitis. INTERVENTIONS: Monitor for signs/symptoms of allergic reaction...Incontinence products per routine and as needed. Provide incontinence care as needed."

A review of Resident #85's ADL (activities of daily living) record for March 2023 revealed missing bladder elimination documentation for 1 of 31-day shifts (3/14), 7 of 31 evening shifts (3/1, 3/9, 3/10, 3/12, 3/14, 3/15, 3/25) and 3 of 31-night shifts (3/16, 3/26, 3/31). A review of April's ADL record revealed missing bladder elimination documentation for 1 of 30 day shifts (4/1), 4 of 30 evening shifts (4/1, 4/2, 4/17, 4/20) and 2 of 30 night shifts (4/14, 4/15). A review of Mays ADL record revealed missing bladder elimination for 2 of 22 day shifts (5/13, 5/22), 5 of 22 evening shifts (5/4, 5/12, 5/18, 5/21, 5/22) and 2 of 22 night shifts (5/16, 5/22).

A review of Resident #85's ADL (activities of daily living) record for March 2023 revealed missing bowel elimination documentation for 2 of 31 day shifts (3/11, 3/14), 7 of 31 evening shifts (3/1, 3/9, 3/10, 3/12, 3/14, 3/15, 3/25) and 3 of 31-night shifts (3/16, 3/26, 3/31). A review of April's ADL record reveals missing bowel elimination documentation for 1 of 30 day shifts (4/1), 4 of 30 evening shifts (4/1, 4/2, 4/17, 4/20) and 2 of 30 night shifts (4/14, 4/15). A review of Mays ADL record reveals missing bowel elimination for 2 of

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22 day shifts (5/13, 5/22), 5 of 22 evening shifts (5/4, 5/12, 5/18, 5/21, 5/22) and 2 of 22 night shifts (5/16, 5/22).

An interview was conducted on 5/21/23 at 2:45 PM with Resident #85. When asked if incontinent care is being provided, Resident #85 stated, "It does not always happen. I sometimes stay wet or have a bowel movement and I am not cleaned up."

An interview was conducted on 5/22/23 at 7:00 AM with CNA (certified nursing assistant) #2. When asked if there is no evidence of incontinence care being provided but the care plan includes the intervention of provide incontinence care, was the care plan being followed, CNA #2 stated, no, it would be not followed.

An interview was conducted on 5/22/23 at 11:00 AM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, it is to provide a detailed plan for each resident's care. When asked if the care plan interventions included incontinence care being provided but there was no evidence of incontinence care being provided, was the care plan followed, LPN #3 stated, no, it is not being followed.

An interview was conducted on 5/22/23 at 3:30 PM with RN (registered nurse) #2. When asked the purpose of the care plan, RN #2 stated, the purpose of care plan is to provide plan of care for our residents. When asked if the incontinence care plan is being followed when there is no evidence of incontinence care being provided, RN #2 stated, no, the care plan is not being followed.

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On 5/23/23 at approximately 2:00 PM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.
3. For Resident #31, the facility staff failed to implement the comprehensive care plan for pain management.

On the most recent MDS (Minimum Data Set), an annual assessment dated 2/19/23, Resident #31 was coded as being cognitively intact in ability to make daily life decisions.

On 5/21/23 at 2:52 PM, an interview was conducted with Resident #31, who stated that the facility runs out of their pain meds and they don't get it.

A review of the comprehensive care plan revealed one dated 10/16/20 for chronic pain that included the intervention "Administer analgesia/medications per orders and note effectiveness" dated 10/16/20.

A review of the physician's orders revealed one dated 10/31/22 for Hydrocodone-Acetaminophen (1) 5-325 mg (milligrams) tablet, 1 tablet every 4 hours when awake, for moderate pain of gastric polyp.

A review of the MARs (medication administration record) for March 2023, April 2023 and May 2023, and the progress notes revealed the following:

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1. On 3/26/23 at 2:00 PM, (Resident #31) did not get this scheduled medication. A nurse's note associated with this documented, "...Pharmacy called will come on next run MD aware."

2. On 4/5/23 at 6:00 PM, (Resident #31) did not get this scheduled medication. A nurse's note associated with this documented, "....Pharmacy made aware. coming on night run, resident aware, no further complaints at this time of or discomfort or pain , No other issues at this time, resident has no problem waiting until next pill run to receive medication. resident own RP. MD made aware."

3. On 5/6/23 at 6:00 AM, 10:00 AM, 2:00 PM and 10:00 PM, (Resident #31) did not get this scheduled medication.

3.a. A nurse's note for the 5/6/23 6:00 AM dose documented, "...Pharmacy to send due to calling pharmacy."

3.b. A nurse's note for the 5/6/23 10:00 AM dose documented, "...Script sent to Rx (pharmacy), waiting for rx to deliver. Resident made aware will continue to monitor."

3.c. A nurse's note for the 5/6/23 2:00 PM dose documented, "...waiting on script from rx, resident made aware will continue to monitor."

3.d. A nurse's note for the 5/6/23 10:00 PM dose documented, "Pharmacy made aware, being delivered tonight, Resident aware, no complaints, MD aware, no new orders, Resident own RP."

A review of the facility Omnicell (automated

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medication dispensing machine) medication supply list was provided. This list included the ordered medication at the ordered dose, therefore, it was available to be administered.

On 5/23/23 at 10:58 AM an interview was conducted with RN #2 (Registered Nurse). She stated staff should check the Omnicell to see if it is in there. When stated that the medication was on the Omnicell list but still was not administered, then was the care plan to administer medication as ordered being followed, she stated that it was not.

On 5/23/23 at 1:54 PM, ASM #1 (Administrative Staff Member) the Director of Nursing, ASM #2 the Regional Vice President of Operations and ASM #3 the Divisional Vice President of Operations, were made aware of the findings.

A care plan policy regarding implementation was requested however only a baseline care plan policy was provided by the facility staff.

No further information was provided.

References:
(1) Hydrocodone-Acetaminophen is used to relieve moderate to severe pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a601006.html

4. For Resident #10, the facility staff failed to implement the comprehensive care plan to administer medication as ordered.

On the most recent MDS (Minimum Data Set), a quarterly assessment dated 4/7/23, Resident #10

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was coded as being moderately impaired in ability to make daily life decisions.

A review of the comprehensive care plan revealed one dated 3/12/20 for depression and anxiety behaviors. This care plan included the intervention "Medications as ordered by physician" dated 3/12/20.

A review of the clinical record revealed two orders dated 1/5/23. One was for Trazodone (1) 25 mg (milligrams) every morning and one was for Trazodone 75 mg every evening at bedtime.

On 5/22/23 at 8:11 AM, LPN #4 (Licensed Practical Nurse) was observed preparing and administering medications to Resident #10. LPN #4 pulled the medication card for Trazodone, 75 mg, removed a pill from the package and placed it in the medication cup and administered it to Resident #10.

Resident #10 was administered the bedtime dose at the time the morning dose was due.

On 5/23/23 at 10:58 AM an interview was conducted with RN #2 (Registered Nurse). She stated that the care plan was not followed if the medication was not given as ordered.

On 5/23/23 at 1:54 PM, ASM #1 (Administrative Staff Member) the Director of Nursing, ASM #2 the Regional Vice President of Operations and ASM #3 the Divisional Vice President of Operations, were made aware of the findings.

A care plan policy regarding implementation was requested however only a baseline care plan policy was provided by the facility staff.

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F 656	Continued From page 54 No further information was provided. References: (1) Trazodone is used to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a681038.html	F 656		
F 657 SS=E	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.	F 657		6/28/23

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F 657	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for three of 43 residents in the survey sample, Residents #41, #63 and #103. The findings include: 1.a. For Resident #41 (R41), the facility staff failed to review and revise the resident's comprehensive care plans for pressure ulcer/injuries that were acquired on 2/1/23. A review of R41's clinical record revealed weekly wound assessments that documented the resident acquired the following pressure injuries: -a pressure injury on the left thigh that was acquired on 2/1/23. -a pressure injury on the left foot that was acquired on 2/1/23. -a pressure injury on the right ischium that was acquired on 2/1/23. A review of R41's comprehensive care plan dated 9/23/22 failed to reveal the care plan was reviewed and revised for the above acquired pressure injuries. On 5/22/23 at 3:21 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is that it's the plan of care and what the staff goes by to care for the residents. RN #2 stated the care plan should be reviewed and revised when a resident develops a new pressure injury. On 5/23/23 at 2:37 p.m., ASM (administrative	F 657	F657 Care Plan Timing and Revision 1. 1.a Resident #41□s skin impairment care plan and weekly wound assessments have been reviewed and updated to reflect wounds on left thigh, left foot and right ischium. 1.b Resident #41□s psychotropic care plan has been reviewed and updated to reflect use of hypnotic and antidepressant medication. 2. Resident #63□s skin impairment care plan has been reviewed and revised to reflect pressure injuries dated 5/10/23. 3. Resident #103 no longer resides in the center. 2. Any resident has the potential to be affected. The DON or designee will conduct an audit of residents with wounds, provision of supervision or the need for supervision related to behaviors/wandering/aggression and use of psychotropic medications will be reviewed to ensure care plans are reflective of current status. 3. The ADON or designee will educate the interdisciplinary team on reviewing and updating care plans to reflect change in condition and /or new orders. Education will be included in new hire orientation. 4. The MDS or designee will complete audit of 5 resident care plans weekly x 4 weeks then monthly x 2 months to ensure care plans are reflective of current status including but not limited to wounds, provision of supervision or the need for supervision related to	

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staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern.

The facility policy titled, "Interim/Baseline Care Planning Policy" failed to document information regarding reviewing and revising the comprehensive care plan.

1.b. For Resident #41 (R41), the facility staff failed to review and revise the resident's comprehensive care plan for psychotropic medication use.

A review of R41's clinical record reveal a physician's order dated 9/21/22 for zolpidem (a hypnotic medication) 5 mg at bedtime and a physician's order dated 5/9/23 for trazadone (an antidepressant medication) 150mg (milligrams) at bedtime.

A review of R41's comprehensive care plan dated 9/23/22 failed to reveal the care plan was reviewed and revised for psychotropic medication use.

On 5/22/23 at 3:21 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is that it's the plan of care and what the staff goes by to care for the residents. RN #2 stated the care plan should be reviewed and revised for psychotropic medication use.

On 5/23/23 at 2:37 p.m., ASM (administrative staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern.

behaviors/wandering/aggression and use of psychotropic medications.

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2. For Resident #63 (R63), the facility staff failed to review and revise the resident's comprehensive care plans for pressure ulcer/injuries that were acquired on 5/10/23.

A review of R63's clinical record revealed weekly wound assessments that documented the resident acquired the following pressure injuries:
-a pressure injury on the left heel that was acquired on 5/10/23.
-a pressure injury on the left leg that was acquired on 5/10/23.

A review of R63's comprehensive care plan dated 4/8/23 failed to reveal the care plan was reviewed and revised for the above acquired pressure injuries.

On 5/22/23 at 3:21 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is that it's the plan of care and what the staff goes by to care for the residents. RN #2 stated the care plan should be reviewed and revised when a resident develops a new pressure injury.

On 5/23/23 at 2:37 p.m., ASM (administrative staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern.

3. For Resident #103, the facility staff failed to review and revise the comprehensive care plan to address the resident's need for increased supervision based on documented behaviors.

Resident #103 had the diagnoses of but not limited to cancer of the prostate and bone and

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dementia. The most recent MDS (Minimum Data Set) was a significant change MDS dated 12/19/22. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status). The resident was coded as having physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others. The resident was coded as behavior symptoms significantly interfered with the resident's ability to participate in activities and social interactions. The resident's behavior symptoms were coded as putting others at significant risk of physical injury. The resident's behavior was coded as being worse since the prior MDS assessment (admission assessment dated 11/28/22 wherein the resident was coded as having delusions and wandering behaviors).

A review of the clinical record for Resident #103 revealed the following notes:

A social worker note dated 12/1/22 documented, "...Charge Nurse also reported behaviors of vulgar language and comments to "shoot their kneecaps off" if [resident] wasn't allowed to go home..."

A nurse practitioner note dated 12/1/22 documented, "...Staff report that [resident] often is wandering the facility and is sometimes not always easily redirected....1. Dementia with behaviors: Noted mild agitation and behaviors..."

A nurse's note dated 12/7/22 documented, "...Resident becoming aggressive towards staff. Resident makes statements about hurting staff."

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A nurse practitioner note dated 12/27/22 documented, "...Recently cane was removed from [resident] possession because of reports of striking out with cane...1. Dementia with behaviors: Noted mild agitation and behaviors...Followed by psychology, continue with recommendations. Recent walking cane removal r/t (related to) aggressive behaviors per staff...."

A nurse's note dated 1/7/23 documented, "Resident was aggressive towards writer at the beginning of the shift. Resident pushed [their] walker towards writer to try and run writer over, [resident] then picked [their] walker up from the floor and again came towards this writer to try and hit again. [Resident] had displayed exit seeking behaviors, such as going to the door that lead to outside and has been trying to get out and find [their] truck. This writer redirected [resident] and informed [resident] [they do] not have truck outside. Hospice was called at 1040am and made aware, however, I am waiting on a call back from the nurse at this time. Activity staff is currently sitting one to one with resident because of exit seeking behavior. Will cont (continue) to monitor and document. RP (responsible party - resident family member) made aware."

A nurse's note dated 1/7/23 documented, "Resident displayed aggressive behavior towards writer this morning. Resident attempted to hit writer with [their] walker twice. [Resident] was redirected and complied. [Resident] also has been displaying exit seeking behaviors at all facility doors. [Resident] is currently sitting one to one with activity staff until CNA (certified nursing assistant) arrives. Hospice called, and made aware, writer is waiting for the On call nurse to call back at this time. Resident is (their) own RP,

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however I called [family member] and [they] did not answer, so I then called [another family member],who visited [resident] yesterday, and made [family member] aware of residents behaviors thus far. Will cont to monitor for changes and/or behaviors."

A nurse's note dated 1/13/23 documented, "1/12/23 3/11 tour. About 17:16 Resident received in back hall of North unit sitting on floor. Charge nurse and other staff with [resident]. Writer was informed by the charge nurse that the resident sat [them] self on the floor. Resident was assisted up and placed in a wheelchair. About 30 min (minutes) later the resident was observed getting out of wheelchair and placing [them] self on the floor. DON (Director of Nursing) and Unit manager notified, came to the unit where they spoke with the resident. Resident was given PRN (as-needed) Ativan 0.25mg (milligrams) for anxiety. DON to speak with Hospice to have [resident] care planned for this behavior. Resident displayed no further behavior after being redirected back to [their] room where [they] had the dinner meal and rested the remainder of the tour."

A nurse's note dated 1/15/23 documented, "Aide overheard resident yelling from her room, yelling get out, aide noted resident from room (number) coming out of resident room, Aide redirected resident back into room and notified Writer, Writer when to talk to resident, resident says that resident came into the room and I told [Resident #103] no get out, resident continue to walk toward the bed and touch my foot then walked out of room, Writer told resident she would talk to resident from room (missing room number)..."

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A physician's note dated 1/16/23 documented, "...exhibits advanced confusion, with nonsensical speech and disorientation. Has been wandering aimlessly into other residents' rooms in past three weeks..."

A nurse practitioner note dated 1/18/23 documented, "Staff concerned over pt (patient) continually wandering, slightly unsteady on [their] feet. [Resident] has been moved closer to nurses station..."

A social worker note dated 1/20/23 documented, "Resident reviewed in IDT (interdisciplinary team) meeting due to behaviors. Resident is often verbally aggressive with staff and wandering into the rooms of other residents after being redirected and not wanting others to use {Resident #103] bathroom. Resident is often restless and has to be re-directed from trying to leave the facility. Resident has been moved to another room with a private bathroom. Resident will continue to be monitored and redirected as needed."

A nurse's note dated 1/27/23 documented. "Resident wandering in/out of multiple residents rooms. Res (resident) not redirectable. Resident went into room (number) with pants down. Residents in (room) scared, and stated they will call the cops if this keeps happening."

A nurse's note dated 1/27/23 documented, "Resident wandering in other Residents rooms majority of shift redirected but with no success. Resident was in a [resident of opposite gender] room with no pants on and [Resident #103] genital exposed, (Opposite gender) Residents voicing concerns of not feeling safe and will call

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the police next time. Unit Manager called Hospice (company) and spoke with Case manager (name) and asked for 1-1 sitter to help keep patient directed to prevent any further incidents which would avoid the police/ At this time hospice has no extra help or able to provide 1/1 and advised if redirecting does not work to send [resident] to ER (emergency room)..."

A nurse's note dated 2/2/23 documented, "Unit Manager was gotten out of Morning meeting from charge Nurse and reported that Resident had assaulted a [opposite gender] Resident and pushed her [other resident] to the floor and the NP (nurse practitioner) was on the unit and is in with [other] resident and asking for [resident] to be sent out to the Emergency Room due to possible Fracture of left shoulder."

A nurse's note dated 2/2/23 documented, "Summary of Discharge: Resident Discharged To: Resident ECO'd (emergency confinement order). Discharged via: Ambulatory....Accompanied by (local) Sheriff Department....Social Service Summary: Resident was involved in an incident where [they] pushed a [another] resident and [other resident] fell and was injured. DON and SW went to the (county) Sheriff Dept to file an ECO and (county) Law Enforcement arrive at the facility around 7pm to pick resident up....Resident's [family member]/emergency contact was contacted...."

A review of the comprehensive care plan for Resident #103 revealed one dated 11/30/22 for "Resident is on antipsychotic therapy..." This care plan was updated on 12/7/22 to include, "verbally abusive and threatening towards staff."

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F 657	Continued From page 63 Another care plan, dated 1/10/23, documented, "Resident shows behaviors by....goes into other residents rooms and lying in their beds." This was updated on 1/23/23 to include "Resident with episode of nudeness in the hallway." The above care plans did not include any interventions for the provision of supervision or the need of increased supervision related to wandering, behaviors, and aggression. On 5/23/23 at 10:58 AM an interview was conducted with RN #2 (Registered Nurse). She stated that the resident required increased supervision and that "I would assign 1:1." She stated that it was her recommendation during a meeting to move Resident #103 and to provide 1:1. She stated that the facility called hospice for 1:1. She stated that it was not their (hospice) responsibility to but it was due to (facility) staffing. She stated that there should have been other interventions in place. She stated the care plan should have been revised for the need of increased supervision. On 5/23/23 at 1:54 PM, ASM #1 (Administrative Staff Member) the Director of Nursing, ASM #2 the Regional Vice President of Operations and ASM #3 the Divisional Vice President of Operations, were made aware of the findings. No further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		6/28/23

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F 658	Continued From page 64 must- (i) Meet professional standards of quality. 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 follow professional standards of practice for four of 43 residents in the survey sample, Residents #57, #10, #349, and #38. The findings include: 1. For Resident #57 (R57) the facility staff failed to correctly transcribe a physician's order for Trulicity (1), resulting in the resident receiving a double dose of the medication on 9/9/22. R57 was admitted to the facility with a diagnosis of diabetes mellitus (2). A review of R57's physician orders revealed the following order dated 9/8/22: "Trulicity Solution Pen-injector 1.5 MG/0.5ML (Dulaglutide). Inject 1.5 mg subcutaneously week every Fri related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY (E11.42)." A review of R57's MAR (medication administration record) for September 2022 revealed R57 received two doses of Trulicity on 9/9/22. A review of R57's progress notes revealed the following: "9/9/22 8:26 p.m. Writer was phoned about resident receiving an extra dose of Trulicity. Writer spoke with both daughters about this. Writer informed them resident will be assessed	F 658	F658 Professional standards of care 1. 1. Resident #57 new order for Trulicity has been reviewed and verified correct transcription. 2. The nurse caring for Resident #10 who administered bedtime dose of Trazodone during morning med pass has been educated on the five rights of medication administration, the nurse practitioner was notified that resident received wrong dose administered, no negative clinical outcome observed. 3. Resident #349 no longer resides in the center. 4. Resident #38□s order for use of hand splints has been clarified for use and frequency of the splint use. 2. Any resident has the potential to be affected. The DON has completed an audit of residents with orders for Trucity to ensure correct dosage/frequency transcribed correctly. The DON or designee will complete a med pass observation on nurse who administered incorrect dose to ensure she is following the 5 rights of med administration. The DON has completed an audit of medications administrated past 24 hours for timeliness of medication administration. The DON or designee will complete an audit of residents with orders for splints/braces to ensure they are being worn as ordered and per care plan. 3. The ADON or designee will educate 100% nurses on process to verify accuracy of transcription of orders. The ADON or designee will educate 100%	

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F 658	Continued From page 65 and monitored. Writer in to assess resident...Blood sugar taken -197...New orders obtained to increase blood sugars to ac (with meals) and hs (at bedtime) x 7 days. Glucagon was added to med orders..." A review of R57's care plan dated 11/26/21 revealed, in part: "Resident is at risk for hypo/hyperglycemia episodes R/T: diabetes ...administer medications as ordered." A review of a facility correction plan dated 9/9/22 revealed, in part: "On 9/9/22, ADON (assistant director of nursing) (Registered Nurse #2) and Admin (administrator) were made aware that resident [resident's initials] received two of her weekly doses of Trulicity, due to an order entry error. The order was changed on 9/8/22 to start on Friday 9/9/22 to increase dosage for Q week *every week) dose. Nurse entered order as two times Q Friday (every Friday)." On 5/23/23 at 10:55 a.m., RN #2 was interviewed regarding the incorrect transcription of R57's Trulicity order. She stated the physician was adjusting the Trulicity in an effort taper it. She stated when the unit manager, who was a new employee, entered the order into the EMR (electronic medical record), the dose had already been administered on 9/9/22. The unit manager incorrectly entered the order so that it would show up to be administered again on 9/9/22. She stated: "[Name of software] picked it up to be given again, instead of a week later." The nurse who administered the second dose of Trulicity on 9/9/22 was unavailable for interview during the survey.	F 658	nurses on following 5 rights of medication administration (right resident, right drug, right dose, right time and right route) and triple check of MAR to med prior to administration of medications. The ADON or designee will educate 100% nurses and C.N.A□s on following physician□s orders for use of splints/braces and clarify if any discrepancies identified. Education will be included in new hire orientation. 4. The DON or designee will audit 5 resident charts weekly x 4 weeks then monthly x 2 months to verify accuracy of transcription of medication orders. The DON or designee will complete 1 random med pass observation weekly x 4 weeks then monthly x 2 months to verify medications administered per 5 rights of med administration. The DON or designee will complete audit of med administration weekly x 4 weeks then monthly x 2 months to verify meds are administered timely per physician orders. The DON/designee will review 2 resident charts/care plans to verify ordered use of splint/brace are in place weekly x 4 weeks then monthly x 2 months The DON or designee will report findings of the audits to the QAPI committee monthly x 3 months for any further recommendations.	

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On 5/23/23 at 2:25 p.m., ASM (administrative staff member) #2, the regional vice president of operations, ASM #3, the regional clinical consultant, and ASM #1, the mobile director of nursing, were informed of these concerns.

No further information was provided prior to exit.

References:
(1) "Dulaglutide (Trulicity) injection is used with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a614047.html.

(2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

2. For Resident #10, the facility staff failed to follow the rights of medication administration, which resulted in the resident getting the wrong dose of the medication, Trazodone (1).

On the most recent MDS (Minimum Data Set), a quarterly assessment dated 4/7/23, Resident #10 was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed two orders dated 1/5/23. One was for Trazodone 25 mg (milligrams) every morning and one was for Trazodone 75 mg every evening at bedtime.

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On 5/22/23 at 8:11 AM, LPN #4 (Licensed Practical Nurse) was observed preparing and administering medications to Resident #10. LPN #4 pulled the medication card for Trazodone, 75 mg, removed a pill from the package, placed it in the medication cup, and administered it to Resident #10.

Resident #10 was administered the bedtime dose at the time the morning dose was due.

On 5/22/23 at 8:44 AM, an interview was conducted with LPN #4. When asked what were the five rights of medication administration, she stated, the right patient, right medication, right dose, right time, and right route. When asked how does she ensure she is following these rights when she is preparing medications, she stated that she checks the medication cards against computer (electronic medication administration record), and checks again when popping the medication out of the package. When asked about the dose of Trazodone that was administered, she pulled the card from the medication cart for the 75 mg dose. When it was noted that this was the incorrect dose for the time that it was administered, she rechecked the cart, and did not locate the 25 mg dose in the drawer with the resident's other medications. On further checking, she found a card of the 25 mg dose in the overstock drawer. When asked if the five rights were followed for this medication, she stated that she did not follow all the checks.

A review of the comprehensive care plan revealed one dated 3/12/20 for depression and anxiety behaviors. This care plan included the intervention "Medications as ordered by physician" dated 3/12/20.

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The facility policy "General Dose Preparation and Medication Administration" was reviewed. This policy documented, "...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in facility's medication administration schedule..."

On 5/23/23 at 1:54 PM, ASM #1 (Administrative Staff Member) the Director of Nursing, ASM #2 the Regional Vice President of Operations and ASM #3 the Divisional Vice President of Operations, were made aware of the findings.

No further information was provided.

References:
(1) Trazodone is used to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a681038.html

3. For Resident #349 (R349), the facility failed to administer medications in a timely manner.

R349 was admitted to the facility with diagnoses that included but were not limited to striatonigral degeneration (1) and fibromyalgia (2).

The MDS (minimum data set) assessment was not due at the time of the survey. On the admission nursing assessment dated 5/13/2023, R349 was assessed as being alert and oriented to person, place, time and situation.

On 5/21/2023 at 2:54 p.m., an interview was conducted with R349 in their room. R349 stated

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that they were new to the facility and had problems getting their medications on time. R349 stated that they took medications for their neurological disorder which had to be given on time to control their symptoms. R349 stated that they felt that the nurses did not understand their diagnoses or the medications enough because they felt that they gave the medications whenever they wanted.

The physician orders for R349 documented in part,
- "Gabapentin Oral Capsule 300 MG (milligram) (Gabapentin) Give 1 capsule by mouth three times a day for pain. Order Date: 05/13/2023."
- "Carbidopa-Levodopa ER (extended release) Oral Tablet Extended Release 50-200 MG (Carbidopa-Levodopa) Give 1 tablet by mouth every 12 hours related to Fibromyalgia (M79.7). Order Date: 05/13/2023."
- "Clonazepam Oral Tablet 0.5 MG (Clonazepam) Give 1 tablet by mouth every 12 hours for multi-system degeneration of the autonomic nervous system. Order Date: 05/13/2023."
- "Carbidopa-Levodopa Oral Tablet 10-100 MG (Carbidopa-Levodopa) Give 0.5 tablet by mouth every 2 hours for for Parkinson's like symptoms while awake, may break tab in half per resident request. Order Date: 05/18/2023."

Review of the medication administration audit report for R349 dated 5/1/2023-5/23/2023 documented the medications listed above. The report documented the Gabapentin scheduled at 8:00 a.m. administered late on 5/16/2023 at 9:36 a.m., and on 5/17/2023 at 10:03 a.m.. The Gabapentin 300mg scheduled at 4:00 p.m. was administered late on 5/15/2023 at 7:52 p.m. The Carbidopa-Levodopa 50-200mg scheduled at

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8:00 a.m. was administered late on 5/16/2023 at 9:36 a.m., and on 5/17/2023 at 10:02 a.m. The Carbidopa-Levodopa 50-200mg scheduled at 8:00 p.m. was administered late on 5/17/2023 at 10:07 p.m. The Clonazepam 0.5mg scheduled at 8:00 a.m. was administered late on 5/16/2023 at 9:36 a.m. and on 5/17/2023 at 10:02 a.m. The Clonazepam 0.5mg scheduled at 8:00 p.m. was administered late on 5/17/2023 at 10:07 p.m. The Carbidopa-Levodopa 10-100mg 0.5 tablet scheduled at 6:00 p.m. was administered late on 5/21/2023 at 9:03 p.m.

Review of the clinical record failed to evidence documentation regarding the late administration of the medications documented above.

On 5/23/2023 at 10:07 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that medications were scheduled to be administered at specific times and they were to be administered within an hour before or an hour after the time. LPN #7 stated that if they were unable to administer the medication within the hour before or hour after timeframe they were supposed to contact the physician to get a one time order to administer the medication late and let the resident know. LPN #7 stated that this should be documented in the nurses notes. LPN #7 stated that the medications were administered on a schedule for the best effects on the disease process, to give the medication enough time to work and not cause a delay in treatment. LPN #7 reviewed the medication administration audit report for R349 and stated that the medications were administered outside of the hour before and hour after window and there should be documentation of the physician notification in the record.

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The facility policy, "General Dose Preparation and Medication Administration" revised 1/1/2022 documented in part, "...Facility Staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in facility's medication administration schedule...Administer medications within timeframes specified by Facility policy or manufacturer's information..."

On 5/23/2023 at 1:54 p.m., ASM (administrative staff member) #1, mobile director of nursing, ASM #2, regional vice president of operations and ASM #5, divisional vice president of operations were made aware of the concern.

No further information was provided prior to exit.

Reference:
(1) Striatonigral degeneration is a neurological disorder caused by a disruption in the connection between two areas of the brain that work together to enable balance and movement-the striatum and the substantia nigra. Striatonigral degeneration is a type of multiple system atrophy (MSA). Symptoms of the disorder resemble some of those seen in Parkinson's disease, including: Rigidity; Instability; Impaired speech; Slow movements. There is no cure for striatonigral degeneration, and treatments for the disorder have variable success. Treatments used for Parkinson's disease are recommended. This information was obtained from the website: https://www.ninds.nih.gov/health-information/disorders/striatonigral-degeneration

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(2) Fibromyalgia is chronic condition that causes pain all over the body, fatigue, and other symptoms. People with fibromyalgia may be more sensitive to pain than people who don't have it. This is called abnormal pain perception processing. This information was obtained from the website: https://medlineplus.gov/fibromyalgia.html

4. For Resident #38 (R38), the facility staff failed to clarify the physician order for the use of hand splints.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/9/2023, 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 on 5/21/2023 at 3:04 p.m. with R38. They stated they were getting range of motion exercises and wears their hand splints at bedtime.

A review of the physician orders dated 3/2/2022, documented in part, "Bilateral hand splints at all times except hygiene."

The comprehensive care plan dated, 12/6/2022, documented in part, "Focus: Able to participate in a Splint Restorative program." The "Interventions" documented in part, "Splint/brace to be worn day and off qhs (every bedtime)."

An interview was conducted on 5/22/2023 at 3:35 p.m. with RN (registered nurse) #2, the MDS coordinator. RN #2 was asked to review the

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F 658	Continued From page 73 physician orders and the care plan above. RN #2 was informed of the interview with R38. When asked if the above order should be clarified, RN #2 stated, yes. ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m. No further information was provided prior to exit.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide ADL care for dependent residents, for three of 43 residents in the survey sample, Residents #38, #101 and #85. The findings include: 1. For Resident #38, the facility staff failed to provide bathing/baths/showers. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/9/2023, in Section G - Functional Status, the resident was	F 677	F677 ADL Care Provided for Dependent Residents 1. 1. Resident # 38 has been assessed to verify he is clean, well-groomed, ADL (activities of daily living)records reviewed to verify documentation of bathing. 2. Resident 101 is no longer at facility. 3. Resident #85□s ADL records have been reviewed for June and resident interviewed to verify his incontinence needs are being met. 2. Any resident can be affected. Unit manager or designee will conduct audit to verify 100% of residents are clean, well groomed and receiving showers/baths and incontinence care. Any variances will	6/28/23

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FARMVILLE HEALTH & REHAB CENTER	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(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 677	Continued From page 74 coded as being totally dependent upon two or more staff members for bathing. The ADL (activities of daily living) documentation for March 2022, revealed the resident did not receive any form of bathing on 3/2/2022, 3/5/2022 and 3/27/2022. The blocks on the form where documentation would be were blank. The ADL (activities of daily living) documentation for April 2022, revealed the resident did not receive any form of bathing on 4/5/2022, 4/6/2022, 4/7/2022, 4/10/2022, 4/23/2022, 4/24/2022, 4/26/2022 and 4/29/2022. The blocks on the form were blank. The ADL (activities of daily living) documentation for May 2022 revealed the resident did not receive any form of bathing on 5/1/2022 through 5/8/2022, 5/13/2022, 5/19/2022 through 5/23/2022, and 5/28/2022. The blocks on the form were blank. The comprehensive care plan dated, 4/24/2019, documented in part, "Focus: The resident has an ADL Self Care Performance Deficit r/t (related to) quadriplegia." The "Interventions" documented in part, "BATH/SHOWER: The resident is totally dependent on (2) staff for a bath." An interview was conducted with CNA (certified nursing assistant) #3 on 5/22/2023 at 2:43 p.m. When asked what the blanks on the ADL documentation meant, CNA #3 stated it meant the CNA didn't chart it. CNA #3 was asked if it's not documented can you tell if it was done, CNA #3 stated, no, it's supposed to be documented in shower sheets and POC (point of care - computer program).	F 677	be addressed. 3. ADON or designees will educate 100% CNA□s on requirements for completion and documentation of ADL care including but not limited to bathing/grooming /cleanliness and incontinence care. Education will be included on new hire orientation. 4. Unit manager or designee will conduct rounds on 5 random residents and review ADL documentation weekly x4 and monthly x2 to verify residents are clean/well groomed, receiving bath/showers and incontinence care. DON or designee will review audit findings and submit report to QAPI committee monthly x3 for any further recommendations	

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F 677	Continued From page 75	F 677		

The facility policy, "Resident Bath/Showering/Scheduling Policy," documented in part, "POLICY: Residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin condition. Staff who have demonstrated competence may bathe the resident via shower, tub bath, whirlpool bath, or bed bath. Bed linens will be changed on baths days and as needed, but minimally once weekly...(E) When the bath or shower is complete, the nursing assistant will document the activity on the shower sheet or in Point of Care section of the electronic record."

ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m.

No further information was provided prior to exit.

2. For Resident #101, the facility staff failed to provide bathing/baths/showers.

On the most recent MDS, a significant change assessment, with an assessment reference date of 5/2/2022, the resident was coded in Section G - Functional Status, the resident was coded as being totally dependent upon one staff members for bathing.

The ADL (activities of daily living) documentation for March 2022, revealed the resident did not receive any form of bathing on 3/1/2022, 3/6/2022, 3/7/2022, 3/12/2022 through 3/14/2022,

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3/20/2022, 3/26/2022 through 3/28/2022 and 3/31/2022. The blocks on the form were blank or documented "na."

The ADL (activities of daily living) documentation for April 2022, revealed the resident did not receive any form of bathing on 4/1/2022, 4/2/2022, 4/3/2022, 4/7/2022, 4/9/2022, 4/10/2022, 4/14/2022, 4/17/2022 through 4/19/2022, 4/21/2022 through 4/23/2022, 4/26/2022, and 4/28/2022. The blocks on the form were blank or documented "na."

The ADL (activities of daily living) documentation for May 2022, revealed the resident did not receive any form of bathing on 5/2/2022, 5/3/2022, 5/10/2022, 5/18/2022 and 5/20/2022. The blocks on the form were blank or documented "na."

The comprehensive care plan documented in part "Focus: The resident has an ADL Self Care Performance Deficit r/t limited mobility, limited ROM (range of motion)...resident does not like showers she prefers bed baths." The "Interventions" documented in part, "BATHING/SHOWERING: the resident requires (1) staff participation with bathing."

An interview was conducted with CNA (certified nursing assistant) #3 on 5/22/2023 at 2:43 p.m. CNA #3 was asked what "na" meant on the ADL documentation, CNA #3 stated, not applicable. When asked what the blanks on the ADL documentation meant, CNA #3 stated it meant the CNA didn't chart it. CNA #3 was asked if it's not documented can you tell if it was done, CNA #3 stated, no, it's supposed to be documented in shower sheets and POC (point of care - computer

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F 677	Continued From page 77	F 677		

program).

ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m.

No further information was provided prior to exit.
3. The facility staff failed to provide ADL (activities of daily living) care, specifically incontinent care for a dependent resident, Resident #85.

Observations were made during the survey period of 5/21/23-5/23/23 on day, evening and night shift. Incontinence care was observed being provided.

Resident #85 was admitted to the facility on 2/18/22 with diagnoses that include but are not limited to: traumatic spinal cord injury, neurogenic bladder, and quadriplegia.

An interview was conducted on 5/21/23 at 2:45 PM with Resident #85. When asked if incontinent care was being provided, Resident #85 stated, "It does not always happen. I sometimes stay wet or have a bowel movement and I am not cleaned up."

Resident #85's most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an assessment reference date of 5/9/23, 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. MDS Section G- Functional Status: coded the resident as total dependence with bed

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mobility, transfers, dressing, eating, hygiene and bathing. Walking did not occur. Locomotion is supervised in motorized wheelchair. A review of MDS Section H- Bowel and Bladder: coded the resident as external catheter for bladder and frequently incontinent for bowel.

A review of Resident #85's ADL (activities of daily living) record for March 2023 revealed missing bladder elimination documentation for 1 of 31 day shifts (3/14), 7 of 31 evening shifts (3/1, 3/9, 3/10, 3/12, 3/14, 3/15, 3/25) and 3 of 31 night shifts (3/16, 3/26, 3/31). A review of April 2023 ADL record revealed missing bladder elimination documentation for 1 of 30 day shifts (4/1), 4 of 30 evening shifts (4/1, 4/2, 4/17, 4/20) and 2 of 30 night shifts (4/14, 4/15). A review of May 2023 ADL record reveals missing bladder elimination for 2 of 22 day shifts (5/13, 5/22), 5 of 22 evening shifts (5/4, 5/12, 5/18, 5/21, 5/22) and 2 of 22 night shifts (5/16, 5/22).

A review of Resident #85's ADL (activities of daily living) record for March reveal missing bowel elimination documentation for 2 of 31 day shifts (3/11, 3/14), 7 of 31 evening shifts (3/1, 3/9, 3/10, 3/12, 3/14, 3/15, 3/25) and 3 of 31-night shifts (3/16, 3/26, 3/31). A review of Aprils ADL record reveals missing bowel elimination documentation for 1 of 30 day shifts (4/1), 4 of 30 evening shifts (4/1, 4/2, 4/17, 4/20) and 2 of 30 night shifts (4/14, 4/15). A review of Mays ADL record reveals missing bowel elimination for 2 of 22-day shifts (5/13, 5/22), 5 of 22 evening shifts (5/4, 5/12, 5/18, 5/21, 5/22) and 2 of 22 night-shifts (5/16, 5/22).

An interview was conducted on 5/22/23 at 7:00 AM with CNA (certified nursing assistant) #2.

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When asked the process for incontinence care, CNA #2 stated, we round at least every two hours and answer call bells also. When asked what blank spaces in documentation mean. CNA #2 stated, that would mean that it was not done.

An interview was conducted on 5/22/23 at 1:00 PM with CNA #11. When asked how incontinence care is provided for residents, CNA #11 stated, we round every two hours. We know the residents and some of them need cleaned up before two hours, so we attend to them also. When asked where it is documented, CNA #11 stated, on the ADL record. When shown the ADL record and asked how there is evidence that incontinence care is provided when there are blanks in the documentation, CNA #11 stated, there is no evidence. If it is not documented, it is not done.

An interview was conducted on 5/22/23 at 3:30 PM with CNA #12. When asked the process for incontinence care, CNA #12 stated, we round every two hours and provide the care. If residents need it more often, they ring their call bell and we clean them up. When asked where incontinence care is documented, CNA #12 stated, it is documented on the ADL record. When asked what it indicates if there are blanks in the ADL documentation, CNA #12 stated, if means that it was not done.

On 5/23/23 at approximately 2:00 PM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional vice president of operations, were made aware of the findings.

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F 677	Continued From page 80 No further information was provided prior to exit.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. 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 assess and monitor the resident's range of motion for the appropriateness of a restorative program, for one of 43 residents in the survey sample. Resident #38. The findings include: For Resident #38 (R38), the facility staff failed to assess and monitor the restorative program used for range of motion.	F 688	F 688 Increase/Prevent Decrease in ROM/Mobility 1. Resident #38 interviewed to verify he is receiving splints and PROM as ordered. Therapy has completed screen to determine appropriate goals for restorative services; orders reconciled with care plan. 2. Any resident has the potential to be affected. The DON or designee will complete audit of residents with orders for splints/braces and PROM/and other restorative modalities to ensure orders being carried out and documentation of	6/28/23

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F 688	Continued From page 81 On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/9/2023, 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 on 5/21/2023 at 3:04 p.m. with R38. When asked if they participated in any form of therapy, R38 stated they were getting range of motion exercises. The comprehensive care plan dated, 12/6/2022, documented in part, "Focus: Able to participate in a Splint Restorative program." The "Interventions" documented in part, "Splint/brace to be worn day and off qhs (every bedtime)." The care plan further documented in part, "Focus: Resident is to receive PROM (passive range of motion) to lower and upper extremities." The "Interventions" documented, "Skills practice: 15 minutes per day. Passive ROM (range of motion). Introduce self and explain procedure. Encourage resident to relax. Position in normal comfortable body alignment." Review of the physician orders failed to evidence documentation of a restorative program. Review of the clinical record failed to evidence documentation of PROM/restorative plan when completed each day An interview was conducted with CNA (certified nursing assistant) #13, the restorative aide, on 5/23/2023 at 11:31 a.m. When asked if R38 was on receiving restorative care, CNA #13 stated they were receiving range of motion to upper and lower extremities and she takes off the splint in	F 688	review of services by the designated Restorative Nursing Coordinator. 3. The DON will educate the ADON and MDS Coordinator on the facility□s policy on Restorative Nursing Program including but not limited to coordination, supervision/oversight, development of care plan, review of progress and required documentation. The ADON or designee will educate 100% nursing staff on requirements for restorative services. Education will be included in new hire orientation. 4. The DON or designee will audit 3 resident charts weekly x 4 weeks then monthly x 2 months to ensure residents are receiving restorative services per facility policy. The DON or designee will report findings of the audits to the QAPI committee monthly x 3 months for any further recommendations.	

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F 688	Continued From page 82	F 688		

the mornings. CNA #13 was asked where she documents the restorative care the resident is receiving, CNA #13 pulled out a copy of a calendar for the month of May 2023 with resident names written on certain dates. When asked if she documents anything in the clinical record, CNA #13 stated, no. CNA #13 was asked how long R38 had been on caseload, CNA #13 stated, "A long time."

An interview was conducted with RN (registered nurse) #2, on 5/23/2023 at 11:52 a.m. When asked how they track the restorative program, and where it is documented, RN #2 stated she was told to put it in the "task" section of the ADL (activities of daily living) documentation. When asked who oversees the restorative program, RN #2 stated she had not been meeting with the restorative aides. When asked where the review of the resident's progress and need to continue the restorative program for range of motion for R38, RN #2 stated, there is no review right now of the program.

The facility policy, "Restorative Nursing Programs" documented in part, "Restorative Coordinator / Licensed Nurse
Responsibilities include but are not limited to:
1. Coordinate the services
2. Identify residents who could benefit from the services
3. Direct and supervise the staff providing services
4. Assist with staff training
5. Review documentation and looks for ways to improve services
6. Help develop the resident's care plan
Documentation:
Each program has specific characteristics that

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F 688	Continued From page 83 are required for documentation. 1. Restorative documentation flow record can be located at the bottom of each restorative program's care plan. 2. Daily documentation is required for verification that the program was performed. 3. Documentation will include time spent providing the program. The program must be provided for a total of 15 minutes per day. These minutes are not necessarily consecutive and may be divided into segments that total 15 minutes per day. 4. Program will be provided six to seven days a week. 5. Episodic documentation to explain why the resident did not participate in the program will be recorded on the back of the form when necessary." ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m. No further information was provided prior to exit.	F 688		
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.	F 689		

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F 689	Continued From page 84 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 adequate supervision for one of 43 residents in the survey sample, Resident #100, which resulted in a fall with fracture. This was cited as harm at past non-compliance. The findings include: For Resident #100 (R100), the facility staff failed to implement the plan of care, while providing ADL (activities of daily living) assistance, which resulted in the resident falling from the bed and suffering a fractured femur (1) resulting in harm. R100 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (2) and hemiplegia (3). On the residents MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/16/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired for making daily decisions. Section G documented R100 being totally dependent on two persons for toileting and transfers and requiring extensive assistance of two persons for bed mobility. The assessment further documented R100 being always incontinent of bowel and bladder and not having any falls since the previous assessment. The progress notes for R100 documented in part: "6/13/2022 17:00 (5:00 p.m.) Overview: Occurrence Details: Resident stated that she	F 689	Past noncompliance: no plan of correction required.	

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rolled off the bed while being changed, she couldn't stop herself from rolling. Immediate Intervention: head to toe assessment, pain assessment, Vs (vital signs) taken, assisted off floor, Md (medical doctor) and RP (responsible party) made aware...Range of motion deficits are previous left sided weakness. Neurological checks are within normal limits. Evidence of pain noted left hip. Pain is acute. Pain level is 7 out of 10. The pain is constant...Residents family/responsible party was notified of occurrence. [Name of family member] resident has left sided weakness and was unable to prevent self from rolling while on the left side, staff educated on assisting with adl care."

- "6/13/2022 17:15 (5:15 p.m.) Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Falls...Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: mobile x-ray stat (now), if not able to come on today send to ER (emergency room) for x-ray..."

- "6/13/2022 22:02 (10:02 p.m.) Note Text: writer called to get update from [Name of hospital] ER on resident and was informed that resident has a left femur fracture and was being shipped to [Name of hospital] ER."

The comprehensive care plan for R100 documented in part, "Resident is at risk for falls r/t (related to) left sided weakness, neuropathy. Actual: Date Initiated: 01/25/2020. Revision on: 09/10/2021." Under "Interventions" it documented in part, "6/13/22 fall with left femur fracture. Sent to ER and admitted. Staff educated on assisting with ADL care using 2 staff for all

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ADL care. Date Initiated: 06/14/2022." The care plan further documented, "Resident has self-care deficit r/t left sided hemiparesis, left hand contracture, left heel arterial ulcer. Date Initiated: 01/25/2020. Revision on: 05/17/2021." Under "Interventions" it documented in part, "Bed Mobility: The resident requires (1-2) staff participation for turning and repositioning in bed. Revision Date: 2/23/2022...Toileting: The resident requires (1-2) staff participation with toileting. Revision Date: 2/23/2022."

The fall risk assessment for R100 dated 5/12/2022 documented the resident being a high risk for falls.

On 5/22/2023 at 8:00 a.m., ASM #1 provided a fall risk evaluation dated 6/13/2022 for R100 which documented a witnessed fall.

On 5/22.2023 at approximately 12:30 p.m., a request was made to ASM #1 for additional information regarding the witnessed fall on 6/13/2022 for R100, including any education provided to the aide as documented in the progress notes, witness statements or any investigation completed. A request was made to speak with the LPN (licensed practical nurse) on duty 6/13/2022 who assessed R100 after the fall and the aide who provided care to R100 at the time of the fall from bed.

On 5/22/2023 at approximately 1:45 p.m., ASM #1 provided a post fall huddle form for R100 dated 6/13/2022 which documented in part, "...Ask Resident...What were you trying to do, go to? What happened? Slid/rolled out of bed...What were they doing? Receiving ADL care...The 5 whys and root cause: Why? CVA.

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Why? left sided weakness. Why? Improper rolling procedure. Why? Decreased ROM (range of motion). Why? General weakness..."

On 5/22/2023 at 3:39 p.m., ASM #1, the mobile director of nursing stated that the aide who provided care for R100 on 6/13/2022 no longer worked at the facility, the LPN who assessed R100 after the fall and the unit manager no longer worked at the facility. ASM #1 stated that they had looked for the education for the aide documented in the progress notes and were unable to find anything. ASM #1 reviewed the MDS for R100 with the ARD of 5/16/2022 and stated that the resident was a total assistance of two persons and the staff member should have had a second person in the room with them and it looked like they did not.

On 5/22/2023 at 12:16 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that they had worked at the facility for six to seven months and was not working when R100 had the fall with injury. CNA #5 stated that they worked with the resident after they returned to the facility after surgery. CNA #5 stated that they reviewed the Kardex (written plan of care) for residents to determine the assistance required for residents and either had another CNA or the nurse assist them when two staff were required for toileting assistance.

On 5/22/2023 at 5:18 p.m., ASM #1, the mobile director of nursing, ASM #2, the regional vice president of operations, ASM #3, the regional clinical consultant and ASM #5, the divisional vice president of operations were made aware of the concern for harm.

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On 5/23/2023 at 8:00 a.m., ASM #2 provided a plan of correction for R100 dated 6/14/2022. ASM #2 stated that the date of compliance for the plan of correction was 9/15/2022. Review of the plan of correction documented a root cause analysis completed for the event, education provided to staff, including the aide involved in the event on proper protocol for bed mobility with competency, evaluation of other potential affected residents in the facility, weekly observations conducted of staff providing care for 12 weeks and mattress audits completed.

Verification of the facility plan of correction was completed by observations, staff interviews and review of the completed mattress audits, completed staff bed mobility competency check offs. No concerns were identified.

No further information was provided prior to exit.

Past non-compliance.

Reference:
(1) femur fracture
You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

(2) cerebrovascular disease, infarction or accident
A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain

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F 689	Continued From page 89 attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (3) hemiplegia Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 689		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide colostomy care and services for one of 43 residents in the survey sample, Resident #41. The findings include:	F 691	F691 Colostomy, Urostomy, or Ileostomy care. 1. The DON will obtain an order for frequency of colostomy bag changes for Resident #41. 2. Any resident has the potential to be affected. An audit of residents with	6/28/23

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F 691	Continued From page 90 For Resident #41 (R41), the facility staff failed to obtain a physician's order for how often the resident's colostomy bag should be changed. R41's comprehensive care plan dated 9/23/22 documented, "Alteration in elimination r/t (related to) colostomy. Change colostomy bag per orders and prn (as needed) ..." A review of R41's clinical record revealed a physician's order dated 9/30/22 for colostomy care every shift but failed to reveal a physician's order for how often the colostomy bag should be changed. On 5/23/23 at 10:45 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated a resident with a colostomy should have a physician's order for how often to change the bag, to make sure this is done frequently. On 5/23/23 at 2:37 p.m., ASM (administrative staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern. The facility policy titled, "Colostomy Irrigation Procedure" failed to document information regarding the changing of colostomy bags. The American Cancer Society documented, "Change the pouching system regularly to avoid leaks and skin irritation. It's important to have a regular schedule for changing your pouch. Don't wait for leaks or other signs of problems, such as itching and burning." This information was obtained from the website: https://www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/colostomy/management.html	F 691	colostomies will be completed by the DON or designee to verify order in place for frequency of colostomy bag changes. 3. The ADON or designee will educate 100% nurses on care and management of colostomies to include order for frequency of colostomy bag changes. Education will be included in new hire orientation. 4. The DON or designee will complete audit weekly x 4 weeks then monthly x 2 months to verify orders for colostomy care and frequency of colostomy bag changes. The DON will report audit findings to the QAPI committee monthly x 3 months for any further recommendations.	

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F 697	Continued From page 91	F 697		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a pain management program for one of 43 residents in the survey sample, Resident #31. The findings include: On the most recent MDS (Minimum Data Set), an annual assessment dated 2/19/23, Resident #31 was coded as being cognitively intact in ability to make daily life decisions. On 5/21/23 at 2:52 PM, in an interview with Resident #31, they stated that the facility runs out of their pain meds (medications) and they don't get it. A review of the physician's orders revealed one dated 10/31/22 for Hydrocodone-Acetaminophen (1) 5-325 mg (milligrams) tablet, 1 tablet every 4 hours when awake, for moderate pain of gastric polyp. A review of the MARs (Medication Administration Record)s for March 2023, April 2023 and May 2023, and the progress notes revealed the	F 697	F697 Pain Management 1. Resident #31□s Medication Administration Record for past 7 days has been reviewed for administration of scheduled pain medication. Resident interviewed to verify she has been receiving her pain med per physician orders/care plan for pain management. 2. Any resident has the potential to be affected. The DON or designee will complete audit of residents with orders for pain medications to verify pain medication have been administered past 7 days and med is available in the med cart and/ or available in Omnicel. 3. The ADON or designee will educate 100 % nurses on responsibility to administer medications per physician orders and process to follow for ordering/reordering control medications and actions to take if medication is not available including access to the Omnicel. 4. The DON or designee will complete audit of 5 residents weekly x 4 weeks then monthly x 2 months to verify pain med administered per physician□s orders and is available in med cart/or Omnicel. The DON or designee will report findings to the	6/28/23

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F 697	Continued From page 92 following: 1. On 3/26/23 at 2:00 PM, Resident #31 did not get the scheduled medication. A nurse's note associated with this documented, "...Pharmacy called will come on next run MD aware." 2. On 4/5/23 at 6:00 PM, Resident #31 did not get the scheduled medication. A nurse's note associated with this documented, "....Pharmacy made aware. coming on night run, resident aware, no further complaints at this time of or discomfort or pain , No other issues at this time, resident has no problem waiting until next pill run to receive medication. resident own RP. MD made aware." 3. On 5/6/23 at 6:00 AM, 10:00 AM, 2:00 PM and 10:00 PM, Resident #31 did not get the scheduled medication. 3a. A nurse's note for the 5/6/23 6:00 AM dose documented, "...Pharmacy to send due to calling pharmacy." 3b. A nurse's note for the 5/6/23 10:00 AM dose documented, "...Script sent to Rx (pharmacy), waiting for rx to deliver. Resident made aware will continue to monitor." Another nurse's note dated 5/6/23 at 12:16 PM documented, "Pharmacy called meds out on next run MD (medical doctor) aware Tylenol (2) order given. Resident aware of same an own RP (responsible party)." 3c. A nurse's note for the 5/6/23 2:00 PM dose documented, "...waiting on script from rx, resident made aware will continue to monitor."	F 697	QAPI committee monthly x 3 months for any further recommendations.	

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Another nurse's note dated 5/6/23 at 4:43 PM documented, "Resident asked writer when pain medication will be here, says day shift nurse made her aware pain medication will arrive on evening shift run, Writer made resident aware pharmacy has not arrived yet, Pharmacy called, medication is on the way with medication run for evening shift. Resident made aware, Resident understood with no complaints at this, polite and cooperative with news, PRN (as-needed) offered, No other concerns, Call bell within reach. MD made aware, no new orders at this time."

3d. A nurse's note for the 10:00 PM dose documented, "Pharmacy made aware, being delivered tonight, Resident aware, no complaints , MD aware, no new orders, Resident own RP."

A review of the comprehensive care plan revealed one dated 10/16/20 for chronic pain that included the intervention "Administer analgesia/medications per orders and note effectiveness" dated 10/16/20.

A review of the Omnicell (automated medication dispensing system) supply list was provided. This list included the above medication at the ordered dose. Therefore, it was available to be administered.

On 5/23/23 at 10:58 AM an interview was conducted with RN #2 (Registered Nurse). She stated that the medication is supposed to be reordered when it gets down to a certain number. She stated that she would reorder around 3 days before it runs out. She stated that the nurse practitioner is in the building if scripts are needed. She stated that the pharmacy delivers every

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morning and every night and that new orders or reorders usually come on the next run or within 24 hours. She stated that a medication should never should run out. She stated staff should check the Omnicell to see if it is in there. When stated that the medication was on the Omnicell list but still was not administered, then was the care plan to administer medication as ordered being followed, she stated that it was not.

The facility policy, "Medication Shortages / Unavailable Medications" documented, "...1. 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....2.2 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 5/23/23 at 1:54 PM, ASM #1 (Administrative Staff Member) the Director of Nursing, ASM #2 the Regional Vice President of Operations and ASM #3 the Divisional Vice President of Operations, were made aware of the findings.

No further information was provided.

References:

1. Hydrocodone-Acetaminophen is used to relieve moderate to severe pain. Information obtained from

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F 697	Continued From page 95 https://medlineplus.gov/druginfo/meds/a601006.html 2. Tylenol is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility	F 700	F700 Bedrails 1. 1. Resident #349 no longer resides in the center. 2. Resident #63 has been	6/28/23

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F 700	Continued From page 96 staff failed to implement bed rail requirements for two of 43 residents in the survey sample, Resident #349 and Resident #63. The findings include: 1. For Resident #349 (R349), the facility failed to assess for bed rail use, obtain consent for use and review risk and benefits of the use of bed rails prior to use. The MDS (minimum data set) assessment was not due at the time of the survey. On the admission nursing assessment dated 5/13/2023 R349 was assessed as being alert and oriented to person, place, time and situation. The resident was assessed as requiring two person assistance for bed mobility, dressing, eating, transfers and toileting. R349 was assessed as not using bed rails. On 5/21/2023 at 2:54 p.m., an interview was conducted with R349 in their room. R349 was observed in bed with a bed rail raised on the right side of the bed. R349 stated that they used the bar to grab onto. Additional observations of R349 in bed with the right side bed rail raised were made on 5/22/2023 at 8:44 a.m. and 1:35 p.m. Review of the physician orders documented in part, "Grab bar to right side of bed to assist with independence with bed mobility every shift for mobility. Order Date: 5/18/2023." The baseline care plan for R349 documented in part, "Resident has ADL (activities of daily living)/self-care deficit related to. Date Initiated:	F 700	assessed for use of bed rails to include risk for entrapment, benefit vs risks with residents informed consent. 2. Any resident has the potential to be affected. The DON or designee will complete 100% audit of residents for use of bed rails to ensure they have been assessed for risk of entrapment, benefit vs risks with informed consent for use. 3. The ADON or designee will educate 100% nurses on requirements for assessment, consent for use and review of risk and benefits of bed rails prior to implementation of bed rails. Education will be included in new hire orientation. 4. The DON or designee will audit 5 resident charts and complete observation to verify assessment, consent for use and risk/benefits for use of bed rail has been completed weekly x 4 weeks then monthly x 2 months. The DON or designee will report audit findings to the QAPI committee monthly x 3 months for any further recommendations.	

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05/15/2023." Under "Interventions" it documented in part, "Evaluate needs for adaptive equipment. Educate/direct the use of assistive devices. Date Initiated: 05/15/2023..."

Review of R349's clinical record failed to evidence a bed rail assessment completed, consent for use or review of the risk and benefits.

On 5/22/2023 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the mobile director of nursing, for evidence of a bed rail assessment for R349.

On 5/23/2023 at 8:00 a.m., ASM #1 provided a bed rail assessment completed for R349 dated 5/22/2023 at 6:28 p.m.

On 5/23/2023 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #4, unit manager. LPN #4 stated when a resident had bed rails the nurse was supposed to complete an assessment on the resident. LPN #4 stated that the assessment asked questions on why the rails were needed. LPN #4 stated that they needed to get a consent for the bed rail use and provide the resident with information on the risks and benefits and why the rails were needed. LPN #4 stated that the bed rail assessment should be completed on admission and quarterly and prior to them being on the bed.

The facility policy, "Bed Rail Policy" revised 4/25/2023 documented in part, "...If a bed or side rail is used, the facility will: a. Assess the potential risks associated with the use of bed rails including the risk of entrapment, prior to bed rail installation. b. Assess the risk versus benefits of using a bed rail and review them with the resident

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or if applicable, the resident ' s representative. c. Obtain informed consent for the installation and use of bed rails prior to the installation..."

On 5/23/2023 at 1:54 p.m., ASM #1, mobile director of nursing, ASM #2, regional vice president of operations and ASM #5, divisional vice president of operations were made aware of the concern.

No further information was provided prior to exit.

2. For Resident #63 (R63), the facility staff failed to assess the resident for the risk of entrapment, review the risks and benefits of bed rails with the resident, and obtain informed consent.

R63's comprehensive care plan dated 5/3/23 documented, "Risk for falls characterized by history of falls, injury, and/or multiple risk factors related to: paraplegia. Grab bars when in bed..." Further review of R63's clinical record failed to reveal documentation that the facility staff assessed the resident for the risk of entrapment, the facility staff reviewed the risks and benefits of bed rails with the resident, or the facility staff obtained informed consent.

On 5/21/23 at 2:21 p.m., R63 was observed lying in bed with the left grab bar in the upright position.

On 5/23/23 at 10:45 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that if a resident is using a grab bar, staff should complete an assessment, provide information to let the resident know why the grab bar is needed, inform the resident of the risks and benefits of using a grab bar, and obtain consent for the use of a grab bar.

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F 700	Continued From page 99 On 5/23/23 at 2:37 p.m., ASM (administrative staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern.	F 700		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §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.	F 732		6/28/23

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F 732	Continued From page 100 §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: Based on observation, staff interview and facility document review, it was determined the facility staff failed to display the current staff posting for one of three days of the survey, 5/21/2023. The findings include: On 5/21/2023 at 12:45 p.m. the staff posting was observed in the front lobby. The posting was dated 5/20/2023. At 3:26 p.m., after the start of the evening shift, the posted information had not been changed, it was dated 5/20/2023. At 5:45 p.m. the posting was dated 5/21/2023. On 5/22/2023 at 11:17 a.m. an interview was conducted with OSM (other staff member) #12, the staffing coordinator. When asked who was responsible for updating the staff posting, OSM #12 stated, she does it. OSM #12 was asked who on the weekends, posts the staffing, OSM #12 stated on Fridays, she puts the papers for the weekend behind the current one. When asked who is delegated to change the posting each day of the weekend, OSM #12 stated, she asks an aide or nurse to do it, but they get busy and don't do it. OSM #12 stated when she got the call that the survey team was in the building, she asked someone to check the staff posting. The facility policy, "Daily Nurse Staffing Posting Policy" documented in part, "PROCEDURE:(1)	F 732	F732 Staff Posting 1. The DON completed 1:1 education with the staffing coordinator on requirements for staff posting. Rounds completed to verify current staff posting was displayed in the front lobby. 2. Any resident has the potential to be affected. Rounds have been completed to verify current staff posting is on display in the front lobby. 3. The ADON or designee will educate 100% nursing staff and Department Managers on requirements for current staff posting and the facility□s protocol to ensure posting is current. Education will be included in new hire orientation. 4. The DON or designee will complete random audit of current staff posting weekly x 4 weeks then monthly x 2 months. The DON or designee will report findings to the QAPI committee monthly x 3 months for any further recommendations.	

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F 732	Continued From page 101 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 (2) Posting requirements: Data will be posted as follows: *In a clear and readable format *In a prominent place readily accessible to residents and visitors (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. ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m. No further information was provided prior to exit.	F 732		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		6/28/23

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F 757	Continued From page 102 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary medication for one of 43 residents in the survey sample, Resident #63. The findings include: For Resident #63 (R63), the facility staff failed to monitor the resident for side effects (bleeding) from the anticoagulant (blocks the activity of certain clotting substances in the blood) medication Eliquis (1). A review of R63's clinical record revealed a physician's order dated 4/7/23 for Eliquis 5 mg (milligrams) twice a day (for a history of	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. Anticoagulant side effect monitoring has been added to Resident #63 medication administration record. 2. Any resident has the potential to be affected. 100% audit has been completed on residents with orders on anticoagulants to verify side effect monitoring is in place. 3. ADON or designee will education 100% RN□s and LPN□s on requirement for monitoring side effects for use of anticoagulant therapy. Education will be included on new hire orientation. 4. DON or designee will conduct audits weekly x4, then monthly x2 for new admits, readmits and new orders to verify	

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F 757	Continued From page 103 pulmonary embolism). A review of R63's March 2023 and April 2023 MARs (medications administration records) revealed the resident was administered Eliquis twice a day from 4/7/23 (the date of admission) until 5/20/23 (except for the days the resident was on a leave of absence from the facility). Further review of R63's clinical record (including the MARs and nurses' notes for April 2023 and May 2023) failed to reveal the resident was monitored for side effects (bleeding) from the Eliquis. R63's comprehensive care plan dated 5/3/23 documented, "Resident is at risk for bleeding/bruising/abnormal labs R/T (related to) receiving blood-thinning medications. Monitor for medication side effects of bruising & internal bleeding..." On 5/23/23 at 10:45 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated residents receiving anticoagulant medication should be monitored for bleeding. LPN #4 stated there is no documentation that staff monitors residents receiving anticoagulant medications for bleeding other than nursing notes. LPN #4 stated she has never seen a documentation sheet to show consistent monitoring. On 5/23/23 at 2:37 p.m., ASM (administrative staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern. The facility policy titled, "Anticoagulation Policy" documented, "Residents will be monitored for possible complications associated with anticoagulation..."	F 757	side effect monitoring is in place for all anti-coagulants. The DON or designee will review audit findings and submit report to QAPI committee monthly x3 for any further recommendations.	

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F 757	Continued From page 104 Reference: (1) "ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF)...Bleeding Risk: ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding." This information was obtained from the website: https://www.eliquis.com/eliquis/hcp/wellcareform?cid=sem_2167331&ovl=isi&gclid=64c052d127001aa9ec1836cd1510884c&gclsrc=3p.ds&	F 757		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide timely laboratory services for one of 43 residents in the survey sample, Resident #87. The findings include: For Resident #87 (R87), the facility staff failed to obtain an ordered urine specimen in a timely manner. On the most recent MDS (minimum data set), a	F 770	F770 Laboratory services 1. The Director of Nursing educated the Nurse Practitioner (NP) on delay in obtaining urinalysis/culture for Resident #87 due to recommendation in her progress notes, order not entered. She was educated to enter order prior to writing progress note. 2. Any resident has the potential to be affected. The DON will complete audit of labs ordered to verify obtained timely, any variances will be reported to the medical provider for further orders	6/28/23

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F 770	Continued From page 105 quarterly assessment with an ARD (assessment reference date) of 4/7/2023, the resident scored six out of 15 on the BIMS (brief interview for mental status) assessment, indicating that the resident was severely impaired for making daily decisions. Section H documented R87 always incontinent of urine. The physician orders for R87 documented in part: - "Urinalysis flex to culture, may I/O (in and out) cath (catheterization) if needed r/t (related to) incontinence. Order Date: 05/05/2023." - "Urinalysis flex to culture, may I/O cath if needed r/t incontinence. Order Date: 05/10/2023." - "Keflex Oral Capsule 750 MG (milligram) (Cephalexin) Give 1 capsule by mouth every 12 hours for for [sic] UTI (urinary tract infection) for 7 Days. Order Date: 05/17/2023." The lab results report "Urinalysis w/Micro, Reflx to Urine Culture" for R87 documented a collection date of 5/14/2023 at 2:20 p.m. The progress notes for R87 documented in part, - "5/5/2023 13:22 (1:22 p.m.) ...On ROS (review of systems) he does have some dysuria (painful urination) and has a history of UTI (urinary tract infection), discussed will have urine sent for culture... AMS (altered mental status)/Dysuria/Hx (history) recent UTI: no dysuria reported. Urine to reflex to culture, may obtain I/O cath if needed r/t pt incontinence. PSA (prostate-specific antigen) (blood test) WNL (within normal limits)..." - "5/10/2023 14:54 (2:54 p.m.) ...On ROS, he does report dysuria, and will have staff check urine for culture..." The comprehensive care plan for R87	F 770	3. The ADON or designee will educate 100% LPNs and RNs on the facility process for reviewing, ordering and obtaining labs. The DON or designee will educate nurse practitioner on exiting with nurses on new orders during her visit. Education will be included on new hire orientation. 4. The DON or designee will audit nurse practitioner progress notes and lab orders weekly x4, then monthly x2 to ensure all labs are completed timely. The DON or designee will review audit findings and submit report to QAPI committee monthly x3 for any further recommendations	

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documented in part, "The resident has history of Urinary Tract
Infection 1.11.23 UTI. Date Initiated: 11/10/2022. Revision on: 01/12/2023... Resident is at risk for infection R/T UTI 5.17.23--5.23.23 ABT (antibiotic) therapy. Date Initiated: 05/18/2023. Revision on: 05/18/2023."

On 5/22/2023 at 4:35 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that when they received an order for a urinalysis they normally collected them in the mornings. LPN #5 stated that they had a person who came each night to collect all of the labs and had been doing that for about two months now. LPN #5 stated that when there were outstanding labs that needed to be collected the order was printed out and hung at the nurses station for the staff to collect. LPN #5 stated that they had a lot of agency staff and some did not give a good report. LPN #5 stated that when there were problems getting a lab specimen if was documented in the progress notes and the physician was notified. LPN #5 stated that if the urinalysis was ordered on 5/5/2023 that it should have been collected before 5/14/2023 or there should be documentation why there was a delay in the collection and that the physician was made aware.

The facility policy "Physician/Provider Orders" revised 12/14/2021 failed to evidence guidance for implementing the physician orders in a timely manner.

On 5/23/2023 at 1:54 p.m., ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, divisional vice president of

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F 770	Continued From page 107 operations were made aware of the findings. No further information was provided prior to exit.	F 770		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to accommodate dietary preferences and allergies for two of 43 residents in the survey sample, Resident #85 and Resident #57. The findings include: 1. Resident #85 had documented lactose intolerance but was served a cheese product. A review of the facility grievance log dated 1/17/23 for Resident #85, revealed, "Resident not happy with dinner tray. Unit manager went to kitchen to replace meal and was told they did not have any more food and that resident or staff could go out and get him something. When unit manager asked for sandwich option, they only had sliced ham which resident declined. (unit	F 806	F806 Resident Allergies, Preferences, Substitutes 1. 1. The Dietary Manager (DM) or designee will visit Resident #85 to ensure he has received meals consistent with physician□s diet order and free of lactose products; his tray ticket has been reviewed to verify accuracy and preferences. 2. The Dietary Manager has visited with Resident #57 to verify she is receiving meals consistent with physician□s diet order and free of beef, pork and dairy products; her tray ticket has been reviewed to verify accuracy. 2. Any resident has the potential to be affected. The DM has completed audit of residents with allergies and food intolerances and verified tray tickets accurate. 3. The DM has educated 100% of	6/28/23

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FARMVILLE HEALTH & REHAB CENTER	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

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F 806	Continued From page 108	F 806		

manager spoke to dietary manager)." The unit manager is no longer employed at the facility.

Resident #85 was admitted to the facility on 2/18/22 with diagnoses that include but are not limited to: traumatic spinal cord injury and quadriplegia.

Resident #85's most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an assessment reference date of 5/9/23, 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 the comprehensive care plan dated 11/1/22 documented in part, "FOCUS: Allergic to Lactose Intolerant, Shellfish, Adhesive.

A review of the physician's order dated 9/20/22 revealed, "Double protein regular diet."

A review of the nursing note dated 1/18/23 at 7:10 PM, revealed, "Resident lactose intolerant and received cheese on sandwich, resident cussing and raising voice in hallway. Resident would like to speak with someone higher up. Resident showing no signs/symptoms of discomfort. Will medicate if symptoms present themselves."

Observations were made during the survey period of 5/21/23-5/23/23 of breakfast, lunch, and supper trays. Resident #85 was provided with no meals that included lactose.

An interview was conducted on 5/21/23 at 2:45 PM with Resident #85. When asked about food preferences being honored, Resident #85 stated,

dietary staff on accuracy of reading and serving meals to physician□s orders and ensuring allergies/intolerances and preferences followed. The ADON or designee will educate 100% nursing staff on adhering to allergies and preferences noted on tray tickets. Education will be included in new hire orientation.
4. The DM or designee will complete random meal observations on 5 residents weekly x 4 weeks then monthly x 2 months to verify accuracy with physician ordered diet and allergies/intolerances/preferences. The DM will report findings to the QAPI committee monthly x 3 months for any further recommendations.

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F 806	Continued From page 109	F 806		

"Yes they are and the food has gotten so much better over the last few weeks with the new administration. It is a 180-degree change from before."

An interview was conducted on 5/22/23 at 1:00 PM with CNA #11. When asked the process for delivery of meal trays, CNA #11 stated, we look at the resident dietary note on the tray and make sure it is the right resident and food.

An interview was conducted on 5/22/23 at 3:30 PM with CNA #12. When asked the process for delivery of meal trays, CNA #12 stated, we make sure it is the right resident and food. When asked how they know it is the right tray, CNA #12 stated, we check the ticket and name on the tray. When asked if there is incorrect food on the tray, what action is taken, CNA #12 stated, we call the kitchen and do not give the tray to the resident.

An interview was conducted on 5/22/23 at 3:45 PM with OSM (other staff member) #9, the dietary aide. When asked the process for ensuring a correct tray for the resident. OSM #9 stated they follow the tray ticket. When asked about notification of a Resident's allergies, OSM #9 stated, there is a list of resident allergies that we follow.

On 5/23/23 at approximately 2:00 PM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional vice president of operations, were made aware of the findings.

A review of the facility's policy "Dining Experience at Mealtimes" dated 5/11/23, revealed, "The

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dining experience will foster independence, promote self-esteem, honor food preferences and make the residents as comfortable and safe as possible. We will provide attractive, nourishing, and palatable meals that minimize negative health outcomes. Meals are to be accurate based on residents' diet order, preference and requests."

A review of the facility's policy "Food Allergy Policy" dated 4/3/22, revealed, "Individuals with food allergies will be provided with safe foods and fluids, and appropriate substitutions to maintain health. If an individual indicates they have a food allergy or allergies, it will be identified and documented in the electronic medical record including the type of allergic reaction as applicable. The food and nutrition services department (FNS) will be notified of food allergies using the facility-specific diet communication process."

No further information was provided

2. For Resident #57 (R57) the facility staff failed to provide food according to the resident's allergies at lunch on 5/23/23. The facility gave the resident pork and beans, and pulled pork on the lunch tray; the resident is allergic to pork.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/17/23, R57 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

On 5/22/23 at 1:02 p.m., R57 was observed sitting up in bed. The lunch tray was open on the overbed table next to the resident. The lunch

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plate contained pulled pork and pork and beans. R57 stated she cannot eat either the pork or the pork and beans because of the Alpha-Gal (1) allergy. The resident stated she cannot have beef or pork products, but the facility serves them to her "all the time." R57 shared the meal ticket that accompanied the lunch tray. A review of the meal ticket revealed: "Allergies: Beef, Pork."

A review of R57's physician orders revealed the following order dated 4/13/22: "Regular diet, Regular texture, Thin consistency, for diet NO BEEF,PORK or Dairy Products."

A review of R57's diagnoses revealed: "7/21/22 Allergy Avoid all Mammalian Meats."

A review of R57's care plan dated 9/22/22 revealed, in part: "Avoid all mammalian meats."

On 5/22/23 at 1:17 p.m., OSM (other staff member) #6, the dietary manager, was interviewed. She stated the facility's EMR (electronic medical record) software generates the meal ticket for each resident, and includes food allergies. She stated the cook who serves the plate is responsible for making sure the resident is not allergic to any of the food on the tray. She stated residents with an Alpha Gal allergy should not receive any pork or beef. She stated she had not been at the facility long enough to know if any current residents have this allergy. When informed of R57's Alpha Gall allergy, she stated the resident should not have received pork and beans, and pulled pork on the lunch tray.

On 5/23/23 at 2:25 p.m., ASM (administrative staff member) #2, the regional vice president of

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F 806	Continued From page 112 operations, ASM #3, the regional clinical consultant, and ASM #1, the mobile director of nursing, were informed of these concerns. No further information was provided prior to exit. NOTES (1) "Alpha-gal syndrome is a type of food allergy. It makes people allergic to red meat and other products made from mammals." This information is taken from the website https://www.mayoclinic.org/diseases-conditions/alpha-gal-syndrome/symptoms-causes/syc-20428608#:~:text=Alpha%2Dgal%20syndrome%20is%20a,alpha%2Dgal%20into%20the%20body.	F 806		
F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services.	F 840		6/28/23

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F 840	Continued From page 113 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to arrange timely outside medical appointments as ordered for one of 43 residents in the survey sample, Resident #85. The findings include: The facility failed to evidence outside neurology and dry needling medical appointments were made timely as ordered for Resident #85. Resident #85 was admitted to the facility on 2/18/22 with diagnoses that include but are not limited to: traumatic spinal cord injury, neurogenic bladder, quadriplegia and hypertension. Resident #85's most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an assessment reference date of 5/9/23, 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 the physician orders revealed the following: -Refer to Neurology related to spasticity on 10/7/22 and 10/12/22. -2/16/23 order: Physical Therapy outpatient referral for muscle rebuilder, dry needling for neck. -3/2/23 orders: Needs referral to outside Physical Therapy for dry needling per pain clinic. Refer to neurology for reported headaches, blacking out spells, and questionable seizures with history of	F 840	F840 Use of Outside Resources 1. Resident #85 appointment for neurology is scheduled for August 28, 2023 at 1:pm, resident has been informed of date and time. An appointment for dry needling cannot be scheduled until seen and referral given by neurology. The DON or designee will educate Unit Manager on requirements for timely scheduling referrals to outside providers. 2. Any resident has the potential to be affected. Unit manager or designee will audit to ensure appointments/referrals have been scheduled. 3. ADON or designee will educate 100% RN□s and LPN□s on following MD/RP recommendations for timely referrals. Education will be included on new hire orientation. 4. The DON will conduct audits weekly x4 and monthly x2 to ensure appointments/referrals have been scheduled timely. The DON or designee will review audit findings and submit report to QAPI committee monthly x3 for any further recommendations.	

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F 840	Continued From page 114	F 840		

brain trauma.
-3/24/23 orders: Refer to Spasticity clinic for evaluation. Refer to Neurology for resident reported headache, blacking out episodes, questionable seizures with history of traumatic brain injury (TBI) and spasticity. Re: original NP order dates of 3/2/2023 and 3/24/2023.

A review of Resident #85's medical record notes revealed:
-3/1/23 at 2:34 PM appointment note revealed, Unit Manager (UM) called outpatient therapy to schedule dry needling for Resident and was asked to fax a consult over for review, upon review they would contact writer back as to if appointment would be given.
-3/2/23 at 4:01 PM NP (nurse practitioner) note revealed, "Spasticity: Chronic, continues with frequent spasms, continue tizanidine. No change to baclofen at this time related to possible absence seizures. PRN (as needed)-methocarbamol available. Awaiting appointment at spasticity clinic for management."
-3/15/23 at 2:00 PM, appointment note revealed, "Writer received call from therapy to notify writer that the Therapist would not be able to accept Resident for dry needling due to review of his medical diagnosis. Resident was notified and is requesting writer to try other cities. Writer will call and submit as he requested.
-3/27/23 at 9:45 AM, appointment note revealed, "Transportation did not pick resident up for appointment. Called and rescheduled pain clinic appointment to Tue, May 2, 2023 @9:00 AM. Pain clinic provided information as per UM request for listing of a provided that could assess/manage resident's complaint of "dry needling" at Physical Therapy. Resident is own RP (responsible party) and aware of transport

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F 840	Continued From page 115	F 840		

failure and rescheduled date.
-3/27/23 at 4:34 PM, social services note revealed, "Residents transportation did not show for 8:15 AM appointment. Transportation coordinator called and dispatch stated the ride was canceled and not rescheduled. Facility staff called pain clinic who stated they would accept resident at 2:15PM on this day. Resident was transported by facility to the 2:15 PM appointment without issue.
-5/4/23 at 6:53 AM, ADON (assistant director of nursing) note revealed, "Facility NP requests referral to Neurology for resident reported headaches, blacking-out episodes, questionable seizures with TBI, and spasticity. Referral ordered and this writer spoke with neurology group, on 5/3/2023 @ 12:30 PM to obtain information to fax referral for appointment. Awaiting neurology group to schedule appointment. This writer also spoke with Physical Therapy at the Lynchburg office, to obtain appointment for resident to receive dry needling procedure to treat spasticity condition. This writer was informed of need for referral from Neurologist to schedule appointment and that Physical Therapy was able to accommodate resident, that this therapy group treats several patients with quadriplegia and to fax referral when resident is seen by Neurologist. Will continue to follow up on appointment status for resident.
-5/4/23 at 8:39 AM, revealed "Writer rounding on unit this AM. Writer knocked on resident door and entered with consent. Writer spoke with resident concerning Neurology and outside PT center referrals and that resident would be advised of appointments as they are scheduled. Resident expressed appreciation to writer for updates.
-5/4/23 at 12:37 PM, ADON note revealed, "This writer advised resident of Neurology appointment

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F 840	Continued From page 116 on 8/28/2023 @ 1:00 PM."	F 840		

An interview was conducted on 5/21/23 at 2:45 PM with Resident #85. When asked if he had been to his outside medical appointments, Resident #85 stated, "Only the pain clinic. I have been waiting for months for appointment to neurologist and for dry needling. There is an appointment now at the end of August."

An interview was conducted on 5/23/23 at approximately 9:00 AM with ASM (administrative staff member) #4, the nurse practitioner. When asked about the outside appointments for Resident #85, ASM #4 stated, "Yes, they were ordered months ago. We did not know that we had to have a neurology consult prior to the dry needling appointment. Then when we tried to get a neurology appointment, there was none in this town." When asked if the Resident would have been sent to another town for the appointment, ASM #4 stated, "Yes, we could send them to Lynchburg, Charlottesville or Richmond."

An interview was conducted on 5/23/23 at 9:20 AM with OSM (other staff member) #12, the transportation coordinator. When asked if she was managing the appointments for Resident #85, OSM #12 stated she only makes the transportation arrangements; the unit manager makes the appointments. When asked if Resident #85's unit manager was here, OSM #12 stated, "No, she no longer works here."

An interview was conducted on 5/23/23 at 9:45 AM with RN (registered nurse) #1. When asked about the appointments for Resident #85 that had been ordered in October 2022, RN #1 stated, "I am following up on this. I started a few months

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F 840	Continued From page 117 ago and am not sure why we never got it resolved. We now have an appointment for the end of August." When asked about the delay in getting appointments, RN #1 stated, "We have changed staff and the appointments did not get made. We did not know we needed neurology appointment first, then had problems getting a neurology appointment." On 5/23/23 at approximately 2:00 PM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional vice president of operations, were made aware of the findings. No further information was provided prior to exit.	F 840		
F 842 SS=D	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	F 842		6/28/23

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F 842	Continued From page 118 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (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;	F 842		

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F 842	Continued From page 119 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 43 residents in the survey sample, Resident #38. The findings include: For Resident #38 (R38), the facility staff failed to document the restorative program activities the resident was participating in. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/9/2023, 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 on 5/21/2023 at 3:04 p.m. with R38. When asked if they participated in any form of therapy, R38 stated they were getting range of motion exercises. Review of the physician orders failed to evidence documentation of a restorative program. An interview was conducted with CNA (certified	F 842	F842 Failure to ensure complete and accurate records 1. Resident #38□s POC documentation has been reviewed to ensure Splinting (and on the TAR for evening nurse to verify application) and PROM modalities are on the Kardex for C.N.A/R.N.A to document restorative activities; Resident #38 was interviewed to confirmed he was getting the services. The ADON/MDS coordinator will be educated by the DON on requirements for documentation of restorative services. 2. Any resident has the potential to be affected. The DON or designee will audit 100% residents to ensure restorative program modalities are on the Kardex for the C.N.A/R.N.A to document services provided. 3. The DON or designee will educate 100% nursing staff on the requirements for restorative services documentation. Education will be included on new hire orientation. 4. The DON or designee will audit 3 resident charts weekly x 4 weeks then monthly x 2 months to ensure residents are receiving restorative services per facility policy with supportive documentation. The DON or designee	

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F 842	Continued From page 120 nursing assistant) #13, the restorative aide, on 5/23/2023 at 11:31 a.m. When asked if R38 was on receiving restorative care, CNA #13 stated they were receiving range of motion to upper and lower extremities and she takes off the splint in the mornings. CNA #13 was asked where she documents the restorative care the resident is receiving, CNA #13 pulled out a copy of a calendar for the month of May 2023 with resident names written on certain dates. When asked if she documents anything in the clinical record, CNA #13 stated, no. CNA #13 was asked how long R38 had been on caseload, CNA #13 stated, "A long time." An interview was conducted with RN (registered nurse) #2, on 5/23/2023 at 11:52 a.m. When asked how you track the restorative program, where it is documented, RN #2 stated she was told to put it in the "task" section of the ADL (activities of daily living) documentation. When asked who oversees the restorative program, RN #2 stated she had not been meeting with the restorative aides. When asked where the review of the resident's progress is and need to continue restorative, RN #2 stated, there is no review right now of the program. The facility policy, "Restorative Nursing Programs" documented in part, "Restorative Coordinator / Licensed Nurse Responsibilities include but are not limited to: 1. Coordinate the services 2. Identify residents who could benefit from the services 3. Direct and supervise the staff providing services 4. Assist with staff training 5. Review documentation and looks for ways to	F 842	will report findings of the audits to the QAPI committee monthly x 3 months for any further recommendations.	

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F 842	Continued From page 121 improve services 6. Help develop the resident's care plan Documentation: Each program has specific characteristics that are required for documentation. 1. Restorative documentation flow record can be located at the bottom of each restorative program's care plan. 2. Daily documentation is required for verification that the program was performed. 3. Documentation will include time spent providing the program. The program must be provided for a total of 15 minutes per day. These minutes are not necessarily consecutive and may be divided into segments that total 15 minutes per day. 4. Program will be provided six to seven days a week. 5. Episodic documentation to explain why the resident did not participate in the program will be recorded on the back of the form when necessary." ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		6/28/23

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 123 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement infection control practices for one of 43 residents, Resident #3, and on one of two units, the North unit. The findings include: 1. For Resident #3 (R3), the facility staff failed to maintain the resident's wheelchair armrests free from torn areas, exposing foam that was unable to be sanitized. On 5/21/23 at 2:15 p.m., R3 was observed sitting in a wheelchair. On the right armrest, a section (approximately 12 inches in length by 0.5 inches	F 880	F880 Infection Control 1. 1. Resident #3 wheelchair armrests have been replaced. 2. The ADON/ICP will complete 1:1 education with LPN #1 on removal of gloves when leaving resident room. 2. Any resident can be affected. Director of Maintenance (DOM) or designee will conduct 100% room rounds to verify all wheelchair (W/C) armrests are in good condition, free of torn areas. ADON/ICP or designee will complete random rounds on all 3 shifts to verify gloves are not observed being worn in the hallway. 3. The DON or designee will educate 100% staff to notify Maintenance of any	

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in width) of the vinyl covering was torn with foam exposed. On the left armrest, a section (approximately four inches in length by 0.5 inches in width) of the vinyl covering was torn with foam exposed. Approximately four inches at the end of the arm rest was wrapped in medical tape.

On 5/22/23 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that usually the therapy department handles the repair or replacement of wheelchair armrests, but the nursing staff will report to the therapy staff if they see an armrest that needs to be fixed.

On 5/22/23 at 3:58 p.m., an interview was conducted with OSM (other staff member) #7, the occupational therapist. OSM #7 stated that he, the director of rehab, and the physical therapist are all over the building so they usually identify wheelchair armrests that are in need of repair, but staff or residents can report armrests in need of repair then the therapy staff will address them.

On 5/23/23 at 10:45 a.m., an interview was conducted with LPN #4. LPN #4 stated if a wheelchair armrest is torn, the armrest can hold organisms and bacteria because it cannot be cleaned properly.

On 5/23/23 at 2:37 p.m., ASM (administrative staff member) #1, the director of nursing, and ASM #2, the regional vice president of operations were made aware of the above concern.

The facility policy titled, "Infection Prevention and Control Program Policy" documented, "It is our policy to maintain an organized, effective facility-wide program designed to systematically

W/C armrests that need replacing and will educate on proper donning/doffing of gloves. Education will be included on new hire orientation.
4. DOM/or designee will conduct 5 random room checks weekly x4 and monthly x2 to verify W/C armrests are in good condition. The ICP or designee will conduct random rounds weekly x 4 weeks then monthly x 2 months to ensure no gloves are worn in hall. The DON or designee will report findings to the QAPI committee monthly x3 for any further recommendations.

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prevent, identify, and control and reduce the risk of acquiring and transmitting infections..."
2. The facility nurse failed to implement infection control practices on one of two units, North Unit.

On 5/22/2023 at 5:55 a.m. LPN (licensed practical nurse) #1 was observed walking down the back hall of North Wing, going towards the nurse's station. LPN #1 had gloves on both hands. When asked why they were wearing gloves in the hallway, LPN #1 stated they were just finishing blood sugar checks.

A second observation was made of LPN #1 on 5/22/2023 at 6:08 a.m. coming towards the nurse's station from the middle hall with a glove on one hand. LPN #1 was asked why they had a glove on in the hallway, LPN #1 stated, they forgot to take it off after doing a blood sugar. When asked what the process was after taking a blood sugar, LPN #1 stated they are supposed to take them [gloves] off before leaving the room and then wash their hands.

The facility policy, "Care of the Diabetic Resident," documented in part, "3. "Finger sticks" (capillary blood samples) measure current blood glucose levels. a) Review the resident's care plan and provide for any special needs of the resident. Equipment Needed: h. Personal protective equipment...d) Don clean gloves... m) Dispose of the lancet in the sharps disposal container. n) Discard disposable supplies in the designated containers. o) Remove gloves and discard into designated container. p) Wash hands."

ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the

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F 880	Continued From page 126 divisional director of operations, were made aware of the above concern on 5/23/2023 at 1:56 p.m. No further information was provided prior to exit.	F 880		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with	F 888		6/28/23

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residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination

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requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully

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F 888	Continued From page 129 vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, it was determined the facility staff failed to implement their COVID-19 vaccination policy to ensure staff were fully vaccinated, for one of eight staff members reviewed, OSM (other staff member) #15, housekeeper. The findings include: OSM #15 only had one dose of the Moderna (1) vaccine administered. On 5/21/2023 at approximately 3:38 p.m., a request was made to RN (registered nurse) #1, the infection preventionist for a completed COVID-19 Staff Vaccination Matrix or a list containing the same information. RN #1 stated that the administrator tracked that information and would provide it. After a review of the COVID-19 Staff Vaccination Matrix received from OSM #11 payroll/human resource coordinator, a sample of staff members were chosen to review for COVID-19 vaccination compliance. OSM #11 confirmed that the matrix	F 888	F888 Vaccination of Facility Staff 1. OSM#15 was informed of requirements for COVID vaccination for employment and opted to resign as she did not wish to proceed with complete series. The DON or designee will educate Director of Human Resources and ICP nurse on current requirements for staff vaccinations. 2. Any resident has the potential to be affected. The Director of HR or designee will complete 100% audit of all staff to verify required COVID vaccination status are up to date. 3. The DON or designee will educate Director of Human Resources and ICP nurse on current staff vaccination requirements to ensure meeting current CDC requirements. Education will be included on new hire orientation. 4. ICP/HR or designee will audit new employees weekly x4 and monthly x2 to verify required vaccinations. The ADM or designee will review audit findings and submit report to QAPI committee monthly	

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included all current active staff members employed at the facility.

Review of the vaccination card for OSM #15, hired in housekeeping, documented one dose of the Moderna vaccine administered on 2/7/2022.

According to Centers for Disease Control, it documented in part, "...Who can receive primary and additional dose(s) of the COVID-19 vaccine by Moderna under the EUI (emergency use instructions)? People who can receive the COVID-19 vaccine by Moderna under EUI are described below. People ages 12 years and older, especially those at higher risk of myocarditis associated with mRNA COVID-19 vaccines, may receive the second primary dose of the COVID-19 vaccine by Moderna 4-8 weeks after the first primary dose. The second dose should not be received earlier than 4 weeks after the first dose. People ages 12 years and older who recently had SARS-CoV-2 infection may receive a second primary dose after a deferral period of 3 months from symptom onset or positive test (if infection was asymptomatic)..." (2)

On 5/22/2023 at 4:56 p.m., an interview was conducted with OSM #11, payroll/human resource coordinator. OSM #11 stated that upon hire they obtained a copy of the staff members COVID-19 vaccination card for the employee file. OSM #11 stated that they could hire a staff member as long as they had at least one dose of the COVID-19 vaccination. When asked who at the facility followed up with the staff members to ensure that they had completed the vaccinations, OSM #11 stated that they did not know that they were responsible for doing this until now. OSM #11 stated that OSM #15 was past the due date for

x3 for any further recommendations.

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the second vaccination dosage.

The facility policy, "Employee COVID-19 Vaccination Policy" revised 4/27/23 documented in part, "...Vaccinations are available to all current and new hires in the Facility and can also be accessed through community-based resources. Staff are required to provide a copy of their vaccination card or other acceptable documentation of administration of the vaccine to confirm their vaccination status, or must have an approved or pending reasonable accommodation to be exempted from the requirements..."

On 5/23/2023 at 1:54 p.m., ASM (administrative staff member) #1, the mobile director of nursing, ASM #2, the regional vice president of operations and ASM #5, the divisional vice president of operations were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) Moderna COVID-19 Vaccine, Bivalent has not been approved or licensed by the FDA, but has been authorized by the FDA, under an Emergency Use Authorization (EUA) to prevent Coronavirus Disease 2019 (COVID-19). The Moderna COVID-19 Vaccine, Bivalent is authorized for use in individuals 6 months through 5 years of age who were previously unvaccinated or vaccinated with one or two doses of Moderna COVID-19 Vaccine (no longer authorized). The Moderna COVID-19 Vaccine, Bivalent is authorized for use in individuals 6 years of age and older who were previously unvaccinated or vaccinated with one or more doses of an approved or authorized monovalent COVID-19 vaccine at least 2 months after receipt of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(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 888	Continued From page 132 monovalent COVID-19 vaccine. Certain additional uses are authorized for immunocompromised patients and patients 65 years and older. This information was obtained from the website: https://eua.modernatx.com/recipients (2) This information was obtained from the website: https://www.cdc.gov/vaccines/covid-19/eui/downloads/Moderna-Caregiver.pdf	F 888		