DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/15/2023 through 5/17/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/15/23 through 05/17/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. (VA00057022-Unsubstantiated, VA00054042-Substantiated without deficiency, VA00054585-Substantiated without deficiency). The census in this 180 certified bed facility was 140 at the time of the survey. The survey sample consisted of 48 resident reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to assess a resident for self-administration of medications, prior to leaving medication on the over bed table,	F 554	**F554** **Correction Action(s):** The miralax noted on resident #76's over bed table was removed and disposed of immediately. The MD was notified of the finding. The resident was assessed using the Folstein mini mental exam by the DON and found not capable of self-administration of medications. One to one inservice with LPN #4 was completed by DON on proper techniques of medication administration.	

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

ADMINISTRATOR 05/31/23

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

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F 554	Continued From page 1 for one of 48 residents in the survey sample, Resident #76. The findings include: The nurse administered morning medications to Resident #76 (R76) then left the cup with Miralax (used to treat constipation) (1) in it, on the overbed table and left the room. On 5/16/2023 at 8:09 a.m. LPN (licensed practical nurse) #4 was observed administering medications to R76. LPN #4 mixed the Miralax in a cup of water and took it into R76's room with the other medications. After administering the other medications, LPN #4 placed the cup of Miralax on the over bed table, then left the room. Observation was made on 5/16/2023 at 8:45 a.m. of R76's room. The cup with the Miralax was still on the overbed table. On the most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 4/13/2023, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Review of the clinical record failed to evidence a physician order for self-administering medications or an assessment for the self-administering of medications. An interview was conducted with LPN #4 on 5/16/2023 at 10:29 a.m. When asked if she left medication on the overbed table for R76. LPN #4 paused and then stated, yes, the Miralax. LPN #4	F 554	**Identification of Deficient Practice(s) and Corrective Action(s):** A 100% med pass observation with nursing staff with each resident to ensure medications are not being self-administered without assessment or a physician order by the DON, Unit Managers and/or designee. Any resident found to be self-administering medications without a physician order and an appropriate Folstein Mini-Mental Exam will be corrected immediately and disciplinary action will be tak..The attending physician will be notified, and a Folstein Mini-Mental Exam will be completed to determine if it is clinically appropriate for the resident to self-administer medications. **Systemic Change(s):** The facility Policy and Procedure for medication administration has been reviewed as well as professional standards of professional practice and no changes are warranted at this time. All licensed staff and the interdisciplinary team will be inserviced by the DON and/or regional nurse consultant on the policy and procedure for self-administration of medications, to include not leaving medications at the bedside unless resident has been deemed appropriate. **Monitoring**: DON is responsible for compliance. The DON, ADON, or Unit Managers will conduct 3 random weekly medication passes with nursing staff.. All negative findings will be corrected at time of discovery and reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion date 6/27/23**	

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F 554	Continued From page 2 stated she is not supposed to do that. When asked if she had returned to R76's room since then, to see if the resident had drank the Miralax, LPN #4 stated, "No, I haven't had a chance." The facility policy, "Administering Medications" documented in part, "Medications shall be administered in a safe and timely manner, and as prescribed....24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 5/16/2023 at 4:40 p.m. No further information was provided prior to exit	F 554		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582	Past noncompliance: no plan of correction required per page 5 of 29.	

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F 582	Continued From page 3 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 582		

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F 582	Continued From page 4 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide notice of Medicare non-coverage for two of three beneficiary protection notification resident reviews, Residents #50 and #62. The findings include: 1. For Resident #50 (R50), the facility staff failed to provide the resident and/or the responsible party with an ABN (advance beneficiary notice) to allow them to make an informed decision regarding their care. R50's last covered day of Medicare part A services was 2/28/2023. R50 was admitted to the facility on 1/11/2023. R50's diagnoses included but were not limited to congestive heart failure, type two diabetes mellitus and cerebral infarction. R50 remained in the facility at the time of the survey. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/17/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. On 5/16/2023 at approximately 10:00 a.m., ASM (administrative staff member) #1, provided a NOMNC (notice of Medicare Non-Coverage) for R50 signed on 2/16/2023 documenting services were ending 2/28/2023. ASM #1 stated that R50 was not provided an ABN notice. ASM #1 stated that the facility had conducted a mock survey in March of 2023 and identified a need for improvement in providing the ABN notices to residents, so they had put a plan of correction in	F 582	Past noncompliance: no plan of correction required.	

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place at that time.

On 5/16/2023 at 10:31 a.m., ASM #1 provided a copy of the plan of correction put in place after the mock survey conducted 3/14/2023-3/17/2023 including a sign-in sheet documenting education provided to OSM (other staff member) #3, the business office manager, regarding ABN completion in a timely manner, informing residents of the right to appeal and how to appeal a notice of discharge. The plan was dated 3/17/2023. ASM #1 stated that this was the only staff member responsible for this task in the facility. ASM #1 stated that the date of compliance for the plan of correction was 4/14/2023.

On 5/16/2023 at 1:41 p.m., an interview was conducted with OSM #3. OSM #3 stated that they were the only person in the facility responsible for providing the ABN and NOMNC to residents in the facility. OSM #3 stated that they provided residents with three days notice before their services ended. OSM #3 stated that they typed up the notices and took them to the resident and had the resident sign them if they were able to. OSM #3 stated that if the resident was not able to sign the notices themselves they had the responsible party sign the notice or notified them by telephone. OSM #3 stated that they had identified an issue with not providing the notices during the mock survey, and they had been educated on the process, and that they now knew which residents required the notices and when to provide them to the resident. OSM #3 stated that they had one resident discharged from Medicare Part A services since the date of compliance for the plan of correction on 4/14/2023 and the proper notices had been

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provided.

Verification of the facility plan of correction was completed by staff interviews and review of the resident discharged from Medicare part A services after the plan of correction date of compliance of 4/14/2023. A review was made of the ABN and NOMNC notice provided for the other resident, Resident #136 (R136), with skilled services ending on 4/15/2023. The ABN notice was signed on 4/11/2023 and the NOMNC was signed on 4/11/2023. The resident remained in the facility. No concerns were identified.

On 5/17/2023 at 12:00 p.m., ASM #5, the regional director of clinical services stated that the facility did not have a policy regarding providing ABN/NOMNC notices and that they followed the state regulations and guidelines.

On 5/16/2023 at approximately 4:30 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the above concern.

No further information was presented prior to exit.

This was cited as past non-compliance.

2. For Resident #62 (R62), the facility staff failed to provide the resident and/or the responsible party with an ABN (advance beneficiary notice) to allow them to make an informed decision regarding their care. R62's last covered day of Medicare part A services was 1/31/2023.

R62 was admitted to the facility on 12/13/2022. R62's diagnoses included but were not limited to

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cerebral infarction, hemiplegia, and congestive heart failure. R62 remained in the facility at the time of the survey.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/2/2023, 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.

On 5/16/2023 at approximately 10:00 a.m., ASM (administrative staff member) #1, provided a NOMNC (notice of Medicare Non-Coverage) for R62 signed 1/26/2023 documenting services ending 1/31/2023. ASM #1 stated that R62 was not provided an ABN notice. ASM #1 stated that the facility had conducted a mock survey in March of 2023 and identified a need for improvement in providing the ABN notices to residents so they had put a plan of correction in place at that time.

On 5/16/2023 at 10:31 a.m., ASM #1 provided a copy of the plan of correction put in place after the mock survey conducted 3/14-3/17/2023 including a sign-in sheet documenting education provided to OSM (other staff member) #3, the business office manager, regarding ABN completion in a timely manner, informing residents of right to appeal and how to appeal notice of discharge dated 3/17/2023. ASM #1 stated that this was the only staff member responsible for this task in the facility. ASM #1 stated that the date of compliance for the plan of correction was 4/14/2023.

On 5/16/2023 at 1:41 p.m., an interview was conducted with OSM #3. OSM #3 stated that

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they were the only person in the facility responsible for providing the ABN and NOMNC to residents in the facility. OSM #3 stated that they provided residents with three days notice before their services ended. OSM #3 stated that they typed up the notices and took them to the resident and had the resident sign them if they were able to. OSM #3 stated that if the resident was not able to sign the notices themselves they had the responsible party sign the notice or notified them by telephone. OSM #3 stated that they had identified an issue with not providing the notices during the mock survey, and they had been educated on the process, and that they now knew which residents required the notices and when to provide them to the resident. OSM #3 stated that they had one resident discharged from Medicare Part A services since the date of compliance for the plan of correction on 4/14/2023 and the proper notices had been provided.

Verification of the facility plan of correction was completed by staff interviews and review of the resident discharged from Medicare part A services after the plan of correction date of compliance of 4/14/2023. A review was made of the ABN and NOMNC notice provided for the other Resident #136 (R136) with skilled services ending on 4/15/2023. The ABN notice was signed on 4/11/2023 and the NOMNC was signed on 4/11/2023. The resident remained in the facility. No concerns were identified.

On 5/16/2023 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the above concern.

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F 582	Continued From page 9 No further information was presented prior to exit. This was cited as past non-compliance.	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized 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	F 656	**F 656** **Corrective Action(s):** Resident #20's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs. Splint was applied to resident upon notification of incident. Resident #66's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs. Physician was immediately notified of missed medication review. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all splints have been audited by DON, ADON, RCC and accuracy of care plans and medical records for those related items have been completed. Residents identified with negative findings have been corrected with care plans updated.	

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	)m page 10 'ge. Facilities must document esident's desire to return to the 'as assessed and any referrals to agencies and/or other appropriate his purpose. je plans in the comprehensive care)ropriate, in accordance with the ts 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, staff interview, and facility document review, the facility staff failed to implement the care plan for two of 48 residents in the survey sample, Residents #20 and #66. The findings include: 1. For Resident #20 (R20), the facility staff failed to implement the care plan to apply hand devices to prevent further contractures. On the following dates and times, R20 was observed in bed. R20's left and right hands were contracted. At all of these observations, the resident was not wearing hand devices/splints: 5/15/23 at 12:20 p.m. and 2:32 p.m.; and 5/16/23 at 8:57 a.m. and 10:46 a.m. A review of R20's physician orders revealed an order dated 2/9/23 which read: "RNP (restorative nursing program) Splinting program seven days a week." A review of R20's care plan dated 8/27/20	F 656	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT, the DON, and nursing staff will be in serviced by the regional nurse consultant on the development, revision, and implementation process of individualized care plans to include the MRR and splint documentation and application. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance of reviewing the care plan for completeness, the implementation of splint application in the resident's care, and timely MRR completion. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 06/27/23**	

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revealed, in part: "RNP splinting program seven days a week."

A restorative nursing aide was not available for interview during the survey.

On 5/16/23 at 4:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of the concern regarding Resident #20 not having hand splints in place.

On 5/16/23 at 3:05 p.m., RNs (registered nurses) #1 and #2, the MDS (minimum data set) coordinators, were interviewed. RN #1 stated the purpose of a care plan is to show the goals for a resident, and to show the staff what the plan of care is. RN #2 stated the care plan tells the staff what they should be doing for a resident, and what they should be watching for. She stated the care plan is a resource for staff if they are unfamiliar with a particular resident's needs.

On 5/17/23 at 10:29 a.m., LPN (licensed practical nurse) #6 stated the purpose of the care plan is for everyone to know what level of care should be given to each resident. She stated the nurse is responsible for making sure the care plan interventions are implemented.

A review of the facility policy, "Care Plans, Comprehensive Person-Centered," revealed, in part: "The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...The comprehensive, person-centered care plan will...aid in preventing or reducing decline in the resident's functional

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12	F 656		

status and/or functional levels."

No further information was provided prior to exit.
2. For Resident #66, the facility staff failed to implement the comprehensive care plan to monitor the pharmacist's drug regime reviews for identification of potential drug interactions.

Resident #66 was admitted to the facility with diagnoses that included but were not limited to: CVA (cerebral vascular accident), anxiety disorder, cognitive communication deficit, and unspecified dementia without behavior/psychosis/mood/anxiety behaviors.

A review of the comprehensive care plan dated 3/20/23, which revealed, ""PROBLEM/NEED: Psychotropic drug use APPROACHES: evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. Monitor pharmacists drug regime review for identification of potential drug interactions. Monitor resident for signs of tremor and document. Report onset of increase to physician."

A review of the physician's orders dated 3/22/23 included, "Buspirone 5 mg (milligram) tablet give one tablet by mouth at bedtime (1), and Mirtazapine 15 mg take one tablet by mouth at bedtime (2) ."

A review of the MRR (monthly regimen reviews) for Resident #66, evidenced June, July, August, September and November 2022; February and May 2023 were present. Missing MRRs were October, December 2022; January, March and April 2023. Five of 12 MRRs were missing.

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F 656	Continued From page 13 An interview was conducted on 5/16/23 at 3:05 PM, with RNs (registered nurses) #1 and #2, MDS (minimum data set) coordinators, were interviewed. RN #1 stated the purpose of a care plan is to show the goals for a resident, and to show the staff what the plan of care is. RN #2 stated the care plan tells the staff what they should be doing for a resident, and what they should be watching for. She stated the care plan is a resource for staff if they are unfamiliar with a particular resident's needs. An interview was conducted on 5/17/23 at 9:30 AM, with ASM (administrative staff member) #5, the regional director of clinical services. When asked if the care plan includes approach of "Monitor pharmacists drug regime review for identification of potential drug interactions" and five of 12 MRRs were missing, was the care plan being followed, ASM #5 stated, no, it is not being followed. On 5/17/23 at 10:30 AM, ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. References: (1) Buspirone is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety. Buspirone is in a class of medications called anxiolytics. It works by changing the amounts of certain natural substances in the brain. https://medlineplus.gov/druginfo/meds/a688005.html. (2) Mirtazapine is used to treat depression.	F 656		

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F 656	Continued From page 14 Mirtazapine is in a class of medications called antidepressants. It works by increasing certain types of activity in the brain to maintain mental balance. https://medlineplus.gov/druginfo/meds/a697009.html	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for the administration of medications, for one of 48 residents in the survey sample, Resident #76. The findings include: The nurse administered morning medications to Resident #76 (R76) then left the cup with Miralax (used to treat constipation) (1) in it, on the overbed table and left the room. On 5/16/2023 at 8:09 a.m. LPN (licensed practical nurse) #4 was observed administering medications to R76. LPN #4 mixed the Miralax in a cup of water and took it into R76's room with the other medications. After administering the other medications, LPN #4 placed the cup of Miralax on the over bed table, then left the room.	F 658	**F658** **Corrective Action(s):** The miralax noted on resident #76's over bed table was removed and disposed of. The MD was notified of the finding. One to one inservice was done with Nurse #4 regarding not leaving medication at bedside. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving medications may have been potentially affected. The DON/designee will conduct medication pass observations with licensed nursing saff to identify any failures in medication administration per standards of practice. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. All licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration. **Monitoring**: DON is responsible for compliance. The DON, ADON, or Unit Managers will conduct 3 random weekly medication passes with nursing staff All negative findings will be corrected at time of discovery and reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion date: 06/27/23**	

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F 658	Continued From page 15 Observation was made on 5/16/2023 at 8:45 a.m. of R76's room. The cup with the Miralax was still on the overbed table. On the most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 4/13/2023, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Review of the clinical record failed to evidence a physician order for self-administering medications or an assessment for the self-administering of medications. The facility policy, "Administering Medications" documented in part, "Medications shall be administered in a safe and timely manner, and as prescribed....24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 5/16/2023 at 4:40 p.m. No further information was provided prior to exit	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688	**F688** **Corrective Action(s):**	

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F 688	Continued From page 16 §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 observation, staff interview, and facility document review, the facility staff failed to provide appropriate treatment and services to prevent further decrease in range of motion for bilateral hand contractures for one of 48 residents in the survey sample, Resident #20. The findings include: For Resident #20 (R20), the facility staff failed to apply hand devices/splints to prevent further contractures. On the following dates and times, R20 was observed in bed. R20's left and right hands were contracted. At all of these observations, the resident was not wearing hand devices: 5/15/23 at 12:20 p.m. and 2:32 p.m.; and 5/16/23 at 8:57 a.m. and 10:46 a.m.	F 688	**F688** **Corrective Action(s):** Resident #20 has been screened by the therapy department and had their Restorative Nursing program reviewed and clarified with the attending physician. Resident #20 has had their comprehensive care plan revised to reflect their current Restorative Nursing programs and appropriate interventions and approaches to meet the resident's needs. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with Restorative nursing orders may have been potentially affected. The DON and/or ADON will conduct a 100% review of all resident's restorative nursing orders to identify residents at risk. Residents identified will be assessed for the development of individualized restorative nursing programs, active rehab interventions, and/or modifications to the current Restorative Nursing Programs to prevent a decline in function. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The therapy department will inservice the nursing staff on the importance of consistently implementing restorative nursing programs. The interdisciplinary team will review each restorative care plan for appropriateness and accurate interventions.	

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F 688	Continued From page 17 A review of R20's physician orders revealed an order dated 2/9/23 which read: "RNP (restorative nursing program) Splinting program seven days a week." A review of R20's care plan dated 8/27/20 revealed, in part: "RNP splinting program seven days a week." A restorative nursing aide was not available for interview during the survey. On 5/16/23 at 4:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. On 5/17/23 at 9:30 a.m., OSM (other staff member) #5, a physical therapy assistant and the rehab program manager, was interviewed. She stated R20 has contractures has contractures in both hands. She stated: "The contractures are well-maintained through the hand splints. She stated the therapy staff screens each resident every quarter. She stated R20's hand splints are actually palm guards. She stated for R20, the palm guards, which ordinarily are put in place to prevent skin breakdown, actually serve a dual role of hand splint and skin protectant. She stated the palm guards are the least restrictive method to prevent R20's contractures from worsening. She stated the palm guards serve to maintain hand joint integrity, and prevent the pain and possible skin breakdown that come from worsening contractures. She stated the resident should be wearing the palm guards "for most of the day and evening, and should be removed overnight."	F 688	**Monitoring:** The DON is responsible for maintaining compliance. The DON or ADON will perform weekly audits of all restorative nursing orders and restorative documentation, and implemented restorative devices. All negative findings will be corrected at time of discovery and appropriate disciplinary action taken for staff members involved. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 06/27/23**	

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F 688	Continued From page 18 On 5/17/23 at 10:29 a.m., LPN (licensed practical nurse) #6 stated she finds out in report from the previous nurse or in the resident's orders that a resident needs a hand splint. She stated if a resident is new to the unit, the therapy staff provides instructions on how to apply the splints. She stated the nurse is ultimately responsible for applying the hand splint. She stated the hand splints are needed to keep the resident's contractures from progressing. On 5/17/23 at 10:45 a.m., CNA (certified nursing assistant) #4 was interviewed. She stated the nurse informs her of residents who need to wear hand splints, and it is her job to make sure the splints are applied. A review of the facility policy, "Resident Mobility and Range of Motion," revealed, in part: "Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM (range of motion)...Interventions may include...the provision of necessary equipment." No further information was provided prior to exit.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689	**F689** **Corrective Action(s):** Resident #342's attending physician has been notified that facility staff failed to ensure a physician ordered fall mat was in place as ordered. A facility incident and accident form has been completed for this incident.	

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F 689	Continued From page 19 by: Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to implement interventions to prevent an injury from a fall, for one of 48 residents in the survey sample, Resident #342. The findings include: For Resident #342 (R342), the facility staff failed to place fall mats beside the resident's bed. On the following dates and times, R342 was observed in bed. Fall mats were not visible on the floor beside the resident's bed on 5/15/23 at 12:04 p.m. and 2:25 p.m., and on 5/16/23 at 8:53 a.m. and 10:22 a.m. On 5/15/23 at 2:25 p.m., R342 was interviewed. The resident stated the facility staff "has never" put fall mats beside the bed. A review of R342's clinical record revealed the resident was admitted to the facility on 5/11/23. A review of R342's orders revealed the following order, dated 5/11/23: "Fall mats to floor while resident in bed. Check placement q (every) shift." The resident's comprehensive assessment and care plan had not yet been developed. On 5/17/23 at 10:29 a.m., LPN (licensed practical nurse) #6 was interviewed. She stated fall mats are ordered for all newly admitted residents until the facility can complete the comprehensive assessment. She stated the nurse is responsible for making sure the fall mats are implemented. On 5/17/23 at 10:45 a.m., CNA (certified nursing	F 689	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered fall mats or other preventive devices to prevent falls and injury may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of all residents with physician ordered fall mats and fall prevention devices to identify residents at risk for inconsistent application of the equipment. All residents identified at risk will be corrected at time of discovery. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will in-service all nursing staff regarding proper use of application of fall prevention equipments to include fall mats and wheelchair and bed alarms to prevent falls. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will perform weekly inspections of all residents with physician order fall prevention devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 06/27/23**	

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F 689	Continued From page 20 assistant) #4 was interviewed. She stated the nurse informs her of residents who need fall mats, and it is her job to make sure the fall mats are down beside the resident's bed when the resident is in the bed. She stated all newly admitted residents have orders for fall mats. On 5/17/23 at 10:56 a.m., ASM (administrative staff member) #2, the director of nursing, was informed of these concerns. No further information was provided prior to exit.	F 689		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756	**F756** **Corrective Action(s):** Resident #66 has had a medication review at the time of discovery. MD was notified of missing monthly medication reviews. A facility Incident and Accident form has been completed for this incident. One to one inservice with the consultant Pharmacist regarding monthly medication review policy and procedure has been completed. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected, the consultant pharmacist will complete a 100% audit of all residents monthly medication reviews for the past 12 months. Any and all negative findings will be corrected at time of discovery and reported to the MD.	

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F 756	Continued From page 21 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence the monthly drug regimen reviews for one of 48 residents, Resident #66. The findings include: Resident #66 was admitted to the facility on 8/19/20 with diagnoses that included but were not limited to: CVA (cerebral vascular accident), dysphagia, anxiety disorder, cognitive communication deficit, unspecified dementia without behavior/psychosis/mood/anxiety behaviors. A review of the comprehensive care plan dated 3/20/23, which revealed, ""PROBLEM/NEED: Psychotropic drug use APPROACHES: evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. Monitor pharmacists drug regime review for identification of potential drug	F 756	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The DON will ensure that the pharmacist reviews all residents monthly utilizing a daily resident census. **Monitoring:** The DON and consultant pharmacist are responsible for maintaining compliance. The DON will perform monthly audits of the pharmacy recommendations to ensure that the recommendations are being reviewed and signed by the attending physician. Any/all negative findings will be corrected at time of discovery. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 6/27/23**	

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F 756	Continued From page 22	F 756		

interactions. Monitor resident for signs of tremor and document. Report onset of increase to physician."

A review of the physician's orders dated 3/22/23, revealed, "Buspirone 5 mg (milligram) tablet, give one tablet by mouth at bedtime. Mirtazapine 15 mg take one tablet by mouth at bedtime."

A review of the MRR (monthly regimen reviews) for Resident #66, evidenced a review in June, July, August, September and November 2022; February and May 2023 were present. There were no MRRs in October and December 2022; January, March and April 2023. Five of 12 MRRs were missing.

An interview was conducted on 5/16/23 at 4:55 PM with ASM (administrative staff member) #4, the regional nurse consultant. When asked if there were MRRs for Resident #66, ASM #4 stated, the pharmacist is having some IT (information technology) issues and we have not been able to obtain them. When asked if these IT issues had existed for months, ASM #4 stated, "No, it has been the last couple of hours since we have asked for them."

An interview was conducted 5/16/23 at 5:00 PM with ASM #2, the director of nursing, who stated, "We are looking for the rest of her MRRs. The pharmacist emails me a monthly report that includes all the residents that have no recommendations and who has recommendations. The pharmacist writes on note specifying the recommendations."

An interview was conducted on 5/17/23 at 9:41 AM with OSM (other staff member) #4, the

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F 756	Continued From page 23	F 756		

pharmacist. When asked about the process for completing medication regimen reviews for the residents, OSM #4 stated, "We are on site every month, it does occur on site every month. Upon admission we will perform the MRR off site." When asked about the five of 12 missing MRR's, OSM #4 stated, "I am still trying to figure out. I moved from the previous pharmacy company to this one to stay with the residents. I follow my customer. This is a new system for me. For some reason she [Resident #66] dropped off. I am having IT look into it. The resident was not uploading to my clinical software." When asked the recommendations for May 16, 2023, OSM #4 stated, "The antidepressant and antianxiety medications are in compliance and I recommended we look at a GDR (gradual dose reduction)."

On 5/17/23 at 10:30 AM, ASM (administrative staff member) #1, the administrator was made aware of the findings.

A review of the facility's "Medication Regimen Review" policy dated 9/18, revealed, "Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the IDT (interdisciplinary team), including the resident, their family, and/or resident representative. The consultant pharmacist reviews the medication regimen and medical

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F 756	Continued From page 24 chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated." No further information was provided prior to exit.	F 756		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a medication error rate less than 5% for three of five residents in the medication administration observation, Residents #76, #84 and #132. The findings include: 1. For Resident #76 (R76), the facility staff failed to administer Lasix (1) as ordered by the physician. On 5/16/2023 at 8:09 a.m. an observation was made of LPN (licensed practical nurse) #4 administering medications to Resident #76. LPN #4 poured the following medications: Senna 8.6 MG (milligram) tablet (1) - one tablet Vitamin B12 1000 MG (2) - one tablet Calcium Citrate 250 MG (3) - one tablet Metoprolol 25 MG tablet (4) Nitrofurantoin 50 MG capsule (5) - one capsule	F 759	**F759** **Corrective Action(s):** Resident #76's attending physician was notified that resident #76 did not receive the ordered dose of Lasix during an observed medication pass. LPN #4 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. MD was notified immediately and medication was administered. Resident #84's attending physician was notified that resident #84 did not receive their prescribed Calcium 500mg/Vitamin D 5 mcg, but was instead administered Calcium 500 mg with Vitamin D 25mcg as ordered by the physician during an observed medication pass. RN #4 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was completed for each medication error.	

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F 759	Continued From page 25 Miralax 17 GM (grams) (6) mixed in 120 ml (milliliters) of water. Review of the physician orders documented the above medication orders. There was a physician order for "Lasix 20 MG Tablet (7), give 1 tab (tablet) PO (by mouth) QD (every day) Dx (diagnosis) CHF (congestive heart failure)." An interview was conducted with LPN #4 on 5/16/2023 at 10:29 a.m. When asked if she gave R76 Lasix during the morning medication administration, LPN #4 pulled the cards holding the medications out of the medication cart. She looked through the cards of medications and there was no card for Lasix. LPN #4 stated, "I guess I didn't give it." When asked should she have given it, LPN #4 stated, yes. The facility policy, "Medication Administration" documented in part, "Medications shall be administered in a safe and timely manner and as prescribed." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 5/16/2023 at 4:40 p.m. No further information was provided prior to exit References: (1) Senna is used to treat constipation. This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/652.html (2) Vitamin B12 is a supplement. This information was obtained from the following website:	F 759	Resident #132 attending physician was notified that resident #132 did not received their prescribed dose of Senna. RN #4 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was completed for each medication error. **Identification of Deficient Practices & Corrective Actions(s):** All residents may have potentially been affected. A 100% medication pass audit of all licensed nurses within the facility will be conducted to identify those nurses at risk for Medication Administration and/or technique errors. A facility Incident & Accident form will be completed for each negative finding as well as one-on-one inservice training and appropriate disciplinary action if warranted for nursing staff observed.	

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F 759	Continued From page 26 https://ods.od.nih.gov/factsheets/VitaminB12-Consumer/ (3) Calcium is a mineral your body needs to build and maintain strong bones and to carry out many important functions. Calcium is the most abundant mineral in the body. This information was obtained from the following website: https://ods.od.nih.gov/factsheets/Calcium-Consumer/ (4) Metoprolol is used alone or in combination with other medications to treat high blood pressure. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682864.html (5) Nitrofurantoin is used to treat urinary tract infections. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682291.html (6) Polyethylene glycol (Miralax) 3350 is used to treat occasional constipation. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a603032.html (7) Furosemide (Lasix) is used to treat edema [fluid retention; excess fluid held in body tissues] caused by various medical problems, including heart, kidney, and liver disease. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682858.html 2. For Resident #84 (R84), RN (registered nurse) #4 failed to administer the physician prescribed medication calcium 500 mg (milligrams)/vitamin D 5 mcg (micrograms) on 5/16/23. RN #4 administered 25 mcg of vitamin D rather than the prescribed dosage.	F 759	**Systemic Change(s):** The facility Policy and Procedure for medication administration has been reviewed and no changes are warranted at this time. All Licensed nursing staff will be inserviced by the DON or ADON on the facility policy and procedure for medication administration. Inservices will include administering medication per physician order and the 5 rights of medication administration. **Monitoring:** DON is responsible for compliance. The DON, ADON, or Unit Managers will conduct 3 random weekly medication passes with nursing staff. All negative findings will be corrected at time of discovery and reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 06/27/23**	

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A review of R84's clinical record revealed a physician's order dated 3/24/23 for calcium 500mg/vitamin D 5mcg once a day.

On 5/16/23 at 8:03 a.m., RN #4 was observed preparing and administering medications to R84. Instead of administering calcium 500mg/vitamin D 5mcg, RN #4 administered vitamin D 25 mcg.

On 5/16/23 at 2:11 p.m., an interview was conducted with RN #4. RN #4 was made aware of the above observation. RN #4 presented R84's medication administration record that documented the physician's order for calcium 500mg/5 mcg vitamin D and stated she didn't know what she gave.

On 5/16/23 at 4:35 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern.

3. For Resident #132 (R132), RN (registered nurse) #4 failed to administer the correct amount of the physician prescribed medication Senna (used to treat constipation). Instead of administering two tablets of Senna to R132, RN #4 only administered one tablet.

A review of R132's clinical record revealed a physician's order dated 3/27/23 for Senna 8.6 mg (milligrams)- two tablets twice a day.

On 5/16/23 at 7:49 a.m., RN #4 was observed preparing and administering medications to R132. RN #4 administered one tablet of Senna to the resident.

On 5/16/23 at 2:00 p.m., an interview was

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F 759	Continued From page 28 conducted with RN #4. RN #4 reviewed R132's physician's order for two tablets of Senna and stated she only gave one tablet. On 5/16/23 at 4:35 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern.	F 759		