STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN HILLS REHABILITATION AND NURSIN(	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 5/15/2023 through 5/16/2023. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirement(s). Three complaints were investigated during the survey. Complaint VA00055059 was substantiated with no deficiencies cited. Complaint VA00056939 was substantiated with deficiencies cited. Complaint VA00058804 was substantiated with deficiencies cited. The census in this 120 certified bed facility was ninety-two at the time of the survey. The survey sample consisted of thirteen current resident reviews (Residents #1, #3, #5 through #15) and two closed record reviews (Residents #2 and #4).	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585	1. The grievance posting was updated to reflect the correct contact information. 2. All residents in the facility have the potential to be impacted by the alleged deficient practice. 3. The Administrator and Social Worker have been educated to ensure the posting of information is accurate. 4. The Administrator/designee will conduct a quality monitoring of the grievance posting	6/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eric Sauer | TITLE: Administrator | (X6) DATE: 6-9-2023

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 585	Continued From page 1 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to	F 585	weekly for 6 weeks to ensure compliance. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/ designee.	

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F 585	Continued From page 2 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure grievance information was current. The facility's posting of the grievance procedure was not updated with the current contact person. The Findings Include:	F 585		

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F 585	Continued From page 3 Review of the facility's grievance procedures (posted in a common area of the facility) documented a contact person (employee) and phone number. On 5/15/23 at 11:15 AM registered nurse (RN #3, MDS coordinator) was asked who the person was identified on the posted grievance information. RN #3 verbalized that the person was a social worker that no longer works at the facility and has been gone for about a year. On 5/15/23 at 11:45 AM the administrator reviewed the posting and verbalized that he is the person that is taking care of grievances and would get the information changed. On 5/16/23 at 4:45 PM the above information was presented to the administrator, and assistant director of nursing. No other information was presented prior to exit conference on 5/16/23.	F 585		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	1. The care plan for resident #3 was revised as indicated. 2. All residents with wounds have the potential to be impacted by the alleged deficient practice. A quality monitoring review was completed for residents with wounds to ensure their care plan was accurate. 3. The MDS nurse and nursing management staff were educated on the implementation/revision of care plans.	6/13/23

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F 657	Continued From page 4 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of fifteen residents in the survey sample (Resident #3). The findings include: Resident #3's plan of care was not revised to discontinue obsolete and discontinued care interventions for a cancerous facial lesion. Resident #3 was admitted to the facility with diagnoses that included squamous cell carcinoma on face, Alzheimer's, anemia, mood disorder, depression, blepharitis, hypothyroidism, dementia with behavioral disturbance, cellulitis, dysphagia, and chronic conjunctivitis. The minimum data set (MDS) dated 1/19/23 assessed Resident #3 with severely impaired cognitive skills. Resident #3's clinical record documented the resident was treated for a cancerous lesion on her forehead above the right eye starting on 6/15/22.	F 657	The wound log will be provided to the MDS nurse on a weekly basis to ensure residents with wounds have an accurate care plan in place. 4. The DON/designee will conduct a quality monitoring of wounds weekly for 6 weeks to ensure the care plan is implemented/revised as indicated. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/ designee.	

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F 657	Continued From page 5 A physician's order was entered on 11/1/22 for cleansing, triple antibiotic ointment dressing twice per day for treatment. A NP note dated 11/1/22 documented no stop date for the antibiotic ointment "as resident has a lesion on forehead that drains into her eye." A weekly non-pressure wound assessment was completed on 11/16/22. This assessment documented the right forehead/eyebrow wound "appears to be cancerous, dark in color, with areas of yellow discoloration noted... protruding away from face, Height of growth is 2.5 cm [centimeters]..." This assessment documented the wound had been present since 6/15/22, was worsening, had signs of infection, was irregular shaped, had foul/necrotic odor and measured 5.5 cm in length and 3 cm in width. Resident #3 was referred and evaluated by a plastic surgeon on 12/5/22. The plastic surgeon consult dated 12/5/22 documented the resident would not allow exam of the right forehead mass and recommended non-surgical treatments due to the size of the lesion and the resident's poor candidacy for surgery. On 1/12/23 a communication sheet to the physician documented, "Refuses meds routinely." A physician's order was entered on 1/12/23 to discontinue the triple antibiotic dressing to the forehead lesion along with eye drops and other oral medications routinely refused by the resident. Resident #3's clinical record documented a nursing note dated 5/9/23 stating, "CNA [certified nurses' aide] in to do round on resident noted blood on hands, under nails and right side of face. Nurse and CNA attempted to clean area to	F 657		

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F 657	Continued From page 6 face and hands. Noted to have maggots on area to forehead. Resident combative during care and did not allow face to be cleaned. On call NP [nurse practitioner]...called order to clean and apply dressing if resident allows...This nurse attempted to clean area again and resident continued to be combative..." A nurse practitioner note dated 5/9/23 documented, "...seen today per request of nursing staff for an evaluation of cancerous lesion on right forehead that is noted to maggots in it...It is imperative that we are able to cleanse the lesion at this time and will adminisiter [administer] IM [intramuscular] Haldol for mild sedation...to provide care... Lesion is semi detached from forehead; it is brown and crusted on surface w/ large amounts of both fresh and old blood covering her forehead, face, and hands. Resident R [right] eye is sealed shut w/ blood w/o [without] edema. There are noted to be large amounts of maggots crawling out of the lesion and point of lesion detaching from forehead...Wound cleaned...after which maggots were suctioned out of wound/lesion...no verbal or non verbal s/s [signs/symptoms] of pain noted..." Nursing documented on 5/9/23 at 5:48 a.m. that Resident #3 continued to pick at forehead and had blood on her face and hair. On 5/9/23 at 2:06 p.m., nursing documented attempts to clean eye and growth on forehead were unsuccessful and the NP gave an order to send the resident to the hospital for further treatment of the maggot infestation. Resident #3 was readmitted to the facility on 5/12/23 following hospitalization and treatment for the maggot infestation of the forehead lesion and facial cellulitis.	F 657		

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F 657	Continued From page 7 Resident #3's plan of care prior to the maggot infestation (last revised 1/21/23) listed the resident had a forehead skin lesion and frequently refused care to lesion, resisted activities of daily living care and most medications. Interventions to prevent complications with the lesion and minimize refusals included wound care with topical ointment, saline cleansing and TAO (triple antibiotic ointment) dressing, encouragement for resident to avoid scratching, short fingernails, good nutrition/hydration, keeping skin clean/dry, plastic surgery consult for removal of lesion, surgical consult, provision of opportunities for positive interaction/attention, encouragement to allow treatment to lesion, pain medications as ordered one half hour before treatment, explanation of procedures, and praise for improved behaviors. The active care plan interventions for treatment of the lesion and care refusals included surgical referrals that were completed in December 2022 and treatment interventions that had been discontinued on 1/12/23. The care plan interventions for the lesion and refusals had not been revised since 1/21/23 and did not include any interventions in rsponse to the maggot infestation or hospitalization. On 5/16/23 at 10:30 a.m., the registered nurse (RN #3) responsible for care planning was interviewed about Resident #3's plan of care. RN #3 stated the last care plan meeting for Resident #3 was on 1/24/23. RN #3 stated the lesion was discussed but nothing was added to the plan since the resident was extremely resistant to care, constantly picked at the lesion, and had been referred to surgery. RN #3 stated the discontinued interventions (referrals, dressing	F 657		

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F 657	Continued From page 8 changes/antibiotic ointment) should have been deleted from the plan when they were completed and/or discontinued. This finding was reviewed with the administrator, director of nursing, regional nurse consultant, and regional director of operations during a meeting on 5/16/23 at 2:10 p.m. No further information was provided regarding Resident #3's plan of care.	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, 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, the facility staff failed to follow professional standards of practice for one of fifteen residents in the survey sample (Resident #3). The findings include: There were no documented assessments or ongoing monitoring of a cancerous skin lesion on Resident #3's forehead for over five months as required in the facility policies for management of wounds and prevention of skin impairments. Resident #3 was admitted to the facility with diagnoses that included squamous cell carcinoma on face, Alzheimer's, anemia, mood disorder, depression, blepharitis, hypothyroidism, dementia with behavioral disturbance, cellulitis, dysphagia, and chronic conjunctivitis. The minimum data set (MDS) dated 1/19/23 assessed	F 658	1. Resident #3's plan of care was revised. The NP examined the resident and documented in the medical record and a treatment was ordered. Weekly wound assessments were also scheduled for the resident. Resident #3 was also added to the wound log and to the list for the wound physician to review. 2. All residents with wounds have the potential to be impacted by the alleged deficient practice. A quality monitoring review was completed for residents in house to determine a baseline skin status for each and to ensure each resident has a weekly skin assessment and treatment as indicated and was updated on the wound log. The findings were also shared with the wound MD. 3. The nursing management team were educated by the RDCS on the wound process/protocol for identifying and routinely monitoring/ assessing wounds.	6/13/23

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F 658	Continued From page 9 Resident #3 with severely impaired cognitive skills. Resident #3's clinical record documented the resident was treated for a cancerous lesion on her forehead above the right eye starting on 6/15/22. A nursing note dated 11/1/22 documented, "Area to forehead increasing in size. Resident picking at area causing bleeding. Difficult to clean due to residents resistance. Information communicated to MD/NP for evaluation." (Sic) A physician's order was entered on 11/1/22 for cleansing, triple antibiotic ointment dressing twice per day for treatment of the lesion. A NP (nurse practitioner) note dated 11/11/22 documented, "...Nursing staff report concerns of lesion to forehead...Large, raised, red lesion with rough texture and irregular borders to right forehead with irritation and bleeding noted..." A weekly non-pressure wound assessment was completed on 11/16/22. This assessment documented the right forehead/eyebrow wound "appears to be cancerous, dark in color, with areas of yellow discoloration noted... protruding away from face, Height of growth is 2.5 cm [centimeters]..." This assessment documented the wound had been present since 6/15/22, was worsening, had signs of infection, was irregular shaped, had foul/necrotic odor and measured 5.5 cm in length by 3 cm in width. Resident #3's clinical record documented treatment of the area with the ordered triple antibiotic ointment (TAO) dressing with the resident refusing most of the attempted applications/dressing changes.	F 658	The staff nurses were educated by the nursing management team on the same. In the morning clinical meeting, orders will be reviewed to determine if any new conditions have been identified. New admissions will also be reviewed to capture newly admitted wounds. At this time, weekly skin assessments will be scheduled and treatments orders verified. This information will be logged on the wound logs and information shared with the MDS nurse for care planning and the medical team for follow up. 4. The DON/designee will conduct quality monitoring of 10 residents with wounds weekly for 6 weeks to: ensure assessments being completed as indicated, orders are present, the care plan is accurate, the wound is logged and the medical team aware. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/ designee.	

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F 658	Continued From page 10 The NP assessed Resident #3 on 1/6/23 and documented the resident had a forehead lesion but listed no assessment or description of the lesion. On 1/12/23 a communication sheet to the physician documented, "Refuses meds [medications] routinely." A physician's order was entered on 1/12/23 to discontinue the triple antibiotic dressing to the forehead lesion along with eye drops and other oral medications routinely refused by the resident. The clinical record from 1/13/23 through 5/8/23 documented no ongoing assessments of the lesion, either routine skin assessments or wound assessments, indicating the status (improving vs. worsening), appearance, size, drainage, odor, condition of surrounding skin/tissue, signs of infection or any pain/discomfort associated with the impairment. The last assessment of the lesion was over five months earlier on 11/16/22 and indicated a worsening condition with signs of infection. Routine skin assessments had not been completed on Resident #3 in over six months with the most recent skin assessment dated 10/24/22. This assessment did not include any mention of the forehead lesion. Resident #3 had not been referred to the consultant wound physician, who came to the facility weekly, for any assessment, monitoring, or treatment recommendations regarding the lesion. Resident #3's clinical record documented a nursing note dated 5/9/23 stating, "CNA [certified nurses' aide] in to do round on resident noted blood on hands, under nails and right side of face. Nurse and CNA attempted to clean area to face and hands. Noted to have maggots on area to forehead. Resident combative during care and	F 658		

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F 658	Continued From page 11 did not allow face to be cleaned. On call NP [nurse practitioner]...called order to clean and apply dressing if resident allows...This nurse attempted to clean area again and resident continued to be combative..." A nurse practitioner note dated 5/9/23 documented, "...seen today per request of nursing staff for an evaluation of cancerous lesion on right forehead that is noted to have maggots in it. Resident has resisted care to this lesion repeatedly over the past months. She has been out for consult w/ [with] dermatology for removal however this was not done D/T [due to] her extreme agitation...In house we have tried ant-anxiety meds to enable staff to provide care to the site and have been unsuccessful...It is imperative that we are able to cleanse the lesion at this time and will adminisiter [administer] IM [intramuscular] Haldol for mild sedation...to provide care... Lesion is semi detached from forehead; it is brown and crusted on surface w/ large amounts of both fresh and old blood covering her forehead, face, and hands. Resident R [right] eye is sealed shut w/ blood w/o [without] edema. There are noted to be large amounts of maggots crawling out of the lesion and point of lesion detaching from forehead...Wound cleaned...after which maggots were suctioned out of wound/lesion...no verbal or non verbal s/s [signs/symptoms] of pain noted..." Nursing documented on 5/9/23 at 5:48 a.m. that Resident #3 continued to pick at her forehead and had blood on her face and hair. On 5/9/23 at 2:06 p.m., nursing documented attempts to clean the eye and forehead lesion were unsuccessful and the NP gave an order to send the resident to the hospital for further treatment of the maggot infestation.	F 658		

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F 658	Continued From page 12 The hospital records dated 5/9/23 documented, "...has a large right forehead skin lesion likely cancerous in nature...This large skin lesion on her forehead has been there for quite some time...within the last 24 hours staff...noticed that she had maggots in the wound...hospitalist was asked to admit given concerns about possible left facial cellulitis...She was given a one-time dose of IV [intravenous] Zosyn. Patient does indeed have maggots in the central part of her wound..." The emergency room assessment of the lesion dated 5/9/23 documented, "...Large golf ball size forehead skin lesion consistent with cancer with centralized section with some bleeding and infestation of maggots. Minimal redness in this area though periorbital area might be a little bit swollen..." The resident was admitted to the hospital and diagnosed with maggot infestation of forehead lesion and facial cellulitis. An adhesive dressing was applied after cleansing and the resident was discharged back to the facility on 5/12/23 with orders to leave the adhesive dressing in place until it naturally came off followed by miconazole sprinkled on wound with a dressing to cover. The comprehensive care plan in place prior to the maggot infestation (revised 1/21/23) listed that Resident #3 had a forehead skin lesion and frequently refused care to lesion, resisted activities of daily living care and most medications. Interventions to prevent complications with the lesion and minimize refusals included wound care with topical ointment, saline cleansing and TAO dressing, encouragement for resident to avoid scratching, short fingernails, good nutrition/hydration, keeping skin clean/dry, plastic surgery consult for removal of lesion, surgical consult, provision of	F 658		

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F 658	Continued From page 13 opportunities for positive interaction/attention, encouragement to allow treatment to lesion, pain medications as ordered one half hour before treatment, explanation of procedures, and praise for improved behaviors. These care plan interventions for treatment of the lesion and care refusals prior to the maggot infestation had not been updated or modified since 1/21/23. There were no interventions listed regarding monitoring of the lesion for signs of infection or complications until after the maggot infestation on 5/9/23. On 5/15/23 at 10:00 a.m., Resident #3 was observed in bed. Resident #3's forehead lesion above the right eye area was mostly covered with an adhesive tape type dressing. Where visible, the lesion was raised, had irregular shaped edges/surface and was dark red/brown in color with no signs of active bleeding. The forehead lesion was visible without direct contact with the resident and was readily observed without resistance or refusal from Resident #3. On 5/15/23 at 1:30 p.m., the registered nurse assistant director of nursing (RN #2) was interviewed about Resident #3. RN #2 reviewed Resident #3's clinical record and stated that prior to 5/9/23, she did not find any nursing notes about the lesion since January (2023). RN #2 stated there were no weekly skin assessments for Resident #3 since 10/24/22. RN #2 stated there was no order for and therefore no prompts in the electronic record for the weekly skin checks. RN #2 stated that the facility had no designated wound nurse and that any wound assessments by nursing were supposed to be documented in the clinical record, if done. RN #2 reviewed Resident #3's clinical record prior to the maggot infestation and stated that no	F 658		

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F 658	Continued From page 14 assessment of the forehead lesion was found since 11/16/22. When questioned about facility method of monitoring resident skin condition, RN #2 stated that all residents were supposed to have weekly skin assessments with any refusals documented. RN #2 stated that she did not know why Resident #3 had no assessments or weekly skin checks prior to the maggot infestation. On 5/15/23 at 3:10 p.m., LPN #2 that routinely cared for Resident #3 was interviewed. LPN #2 stated Resident #3 frequently "picked" at the forehead lesion and scratched it. When questioned further, LPN #2 stated that the nurses were responsible for weekly skin checks and performing any ordered wound care. On 5/15/23 at 3:35 p.m., the assistant director of nursing (RN #2) was interviewed again about any ongoing assessments of the forehead lesion prior to 5/9/23. RN #2 stated that Resident #3 frequently refused care/treatment but if skin assessments had been attempted, it was not documented. RN #2 stated that there was no order entered for any scheduled assessment of the lesion. On 5/16/23 at 8:50 a.m., the survey team met with and interviewed the administrator, director of nursing (DON), assistant director of nursing (RN #2) and the unit manager (LPN #3) about Resident #3's maggot infestation. The unit manager stated routine skin assessments were supposed to be completed weekly on all residents. The DON stated because the lesion did not require care or measurements, that nurses would only document an assessment if the area was bleeding or started coming detached. The DON stated assessments were expected when there was a change. When	F 658		

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F 658	Continued From page 15 asked if there had been changes in the lesion, the DON stated there may have been changes in the lesion since the resident frequently scratched and picked at the area. The unit manager stated nurses had not reported to her any concerns or problems with the lesion prior to the maggot infestation on 5/9/23. The DON was asked again about expected monitoring of the lesion. The DON stated, "It was not considered a wound." When asked what should have happened to prevent the maggot infestation, the DON stated, "If it is part of her and closed, then referral to consults was all that was needed." On 5/16/23 at 9:40 a.m., the physician (other staff #9) caring for Resident #3 was interviewed. The physician stated he was "surprised" that the resident had not been referred to the facility's wound consultant that provided weekly assessments and treatment recommendations for wounds. The facility's policy titled Documentation of Wound Treatments (revised 12/1/22) documented, "The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment." This policy documented, "...Wound assessments are documented on Admission Skin Assessment upon admission, daily x 3 days, weekly using the Weekly Skin Review, and as needed if the resident or wound condition deteriorates...The following elements are documented as part of a compete wound assessment using the Pressure and Non-Pressure Wound Log...Type of wound...anatomical location...degree of skin loss if non-pressure...Measurements: height, width, depth...Description of wound characteristics...Color of the wound bed...Type of	F 658		

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F 658	Continued From page 16 tissue...Condition of the peri-wound skin...Presence, amount, and characteristics of wound drainage/exudate...Presence or absence of odor...Presence or absence of pain...Wound treatments are documented at the time of each treatment on the Treatment Administration Record...If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry, intact)...Additional documentation shall include...Date and time of wound management treatments...Weekly progress towards healing and effectiveness of current intervention...Any treatment for pain...Modifications of treatments or interventions...Notifications to physician and/or responsible party regarding wound or treatment changes..." The facility's policy titled Skin Assessment (reviews 12/1/22) documented, "It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management...A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition...Document observations...type of wound...Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) (Pressure and Non-pressure Wound Log)...Document if resident refused assessment and why...Document other information as indicated or appropriate." This finding was reviewed with the administrator, director of nursing, regional nurse consultant and regional director of operations during a meeting on 5/16/23 at 2:10 p.m. The regional nurse consultant (administrative staff #3) stated at this	F 658		

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F 658	Continued From page 17 meeting they had no other information or documentation to present regarding assessment of Resident #3's lesion.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess and implement care interventions for a skin lesion for one of fifteen residents in the survey sample (Resident #3). The findings include: Resident #3 had no ongoing assessments, monitoring or care interventions attempted for a cancerous lesion on the forehead. After over three months with no attempted treatments or monitoring, the lesion was found to be infested with maggots, requiring hospitalization for treatment of the infestation and facial cellulitis. Resident #3 was admitted to the facility with diagnoses that included squamous cell carcinoma on face, Alzheimer's, anemia, mood disorder, depression, blepharitis, hypothyroidism, dementia with behavioral disturbance, cellulitis, dysphagia, and chronic conjunctivitis. The minimum data set (MDS) dated 1/19/23 assessed Resident #3 with severely impaired cognitive	F 684	1. Resident #3's plan of care was revised. The NP examined the resident and documented in the medical record and a treatment was ordered. Weekly wound assessments were also scheduled for the resident. Resident #3 was added to the wound log and to the list for the wound physician to review. 2. All residents with wounds have the potential to be impacted by the alleged deficient practice. A quality monitoring review was completed for residents in house to determine a baseline skin status for each and to ensure each resident has a weekly skin assessment and treatment as indicated and was updated on the wound log. The findings were also shared with the wound MD. 3. The nursing management team were educated by the RDCS on the wound process/protocol for identifying and routinely monitoring/ assessing wounds.	6/13/23

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F 684	Continued From page 18 skills. Resident #3's clinical record documented the resident was treated for a cancerous lesion on her forehead above the right eye starting on 6/15/22. A nursing note dated 11/1/22 documented, "Area to forehead increasing in size. Resident picking at area causing bleeding. Difficult to clean due to residents resistance. Information communicated to MD/NP for evaluation." (Sic) A physician's order was entered on 11/1/22 for cleansing, triple antibiotic ointment and a dressing twice per day for treatment of the lesion. A NP note dated 11/1/22 documented no stop date for the antibiotic ointment "...as resident has a lesion on forehead that drains into her eye." A NP note dated 11/11/22 documented, "...Nursing staff report concerns of lesion to forehead...Large, raised, red lesion with rough texture and irregular borders to right forehead with irritation and bleeding noted..." A weekly non-pressure wound assessment was completed on 11/16/22. This assessment documented the right forehead/eyebrow wound "appears to be cancerous, dark in color, with areas of yellow discoloration noted... protruding away from face, Height of growth is 2.5 cm [centimeters]..." This assessment documented the wound had been present since 6/15/22, was worsening, had signs of infection, was irregular shaped, had foul/necrotic odor and measured 5.5 cm in length by 3 cm in width. Resident #3 was referred and evaluated by a plastic surgeon on 12/5/22. The plastic surgeon consult dated 12/5/22 documented the resident would not allow exam of the right forehead mass	F 684	The staff nurses were educated by the nursing management team on the same. In the morning clinical meeting, orders will be reviewed to determine if any new conditions have been identified. New admissions will also be reviewed to capture newly admitted wounds. At this time, weekly skin assessments will be scheduled and treatments orders verified. This information will be logged on the wound logs and information shared with the MDS nurse for care planning and the medical team for follow up. 4. The DON/designee will conduct random quality monitoring of 10 residents with wounds weekly for 6 weeks to: ensure assessments being completed as indicated, orders are present, the care plan is accurate, the wound is logged and the medical team aware. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/ designee.	

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F 684	Continued From page 19 and recommended non-surgical treatments due to the size of the lesion and the resident's poor candidacy for surgery. Resident #3's clinical record documented continued treatment of the area with the ordered triple antibiotic ointment (TAO) dressing with the resident refusing most of the attempted applications/dressing changes. The NP assessed Resident #3 on 1/6/23 and documented the resident had a forehead lesion but documented no assessment or status of the lesion. On 1/12/23, a communication sheet to the physician documented, "Refuses meds [medications] routinely." A physician's order was entered on 1/12/23 to discontinue the triple antibiotic dressing to the forehead lesion along with eye drops and other oral medications routinely refused by the resident. As of 5/8/23, there were no further care orders and/or interventions implemented for Resident #3's forehead lesion after the discontinued treatment on 1/12/23. The record from 1/13/23 through 5/8/23 documented no further attempts at assessing, cleansing, treating, or covering the lesion with any type of dressing. There were no ongoing assessments of the lesion indicating the status (improving vs. worsening), appearance, size, drainage, odor, condition of surrounding skin/tissue, signs of infection or any pain/discomfort associated with the impairment. The last assessment of the lesion was over five months earlier on 11/16/22 indicating a worsening condition with signs of infection. Routine skin assessments had not been completed on Resident #3 in over six months with the most	F 684		

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F 684	Continued From page 20 recent skin assessment dated 10/24/22. This assessment made no mention of the forehead lesion. Resident #3's lesion had not been referred to the consultant wound physician that came weekly for any assessment/monitoring and treatment recommendations. Resident #3's clinical record documented a nursing note dated 5/9/23 stating, "CNA [certified nurses' aide] in to do round on resident noted blood on hands, under nails and right side of face. Nurse and CNA attempted to clean area to face and hands. Noted to have maggots on area to forehead. Resident combative during care and did not allow face to be cleaned. On call NP [nurse practitioner]...called order to clean and apply dressing if resident allows...This nurse attempted to clean area again and resident continued to be combative..." A nurse practitioner note dated 5/9/23 documented, "...seen today per request of nursing staff for an evaluation of cancerous lesion on right forehead that is noted to have maggots in it. Resident has resisted care to this lesion repeatedly over the past months. She has been out for consult w/ [with] dermatology for removal however this was not done D/T [due to] her extreme agitation...In house we have tried ant-anxiety meds to enable staff to provide care to the site and have been unsuccessful...It is imperative that we are able to cleanse the lesion at this time and will adminisiter [administer] IM [intramuscular] Haldol for mild sedation...to provide care... Lesion is semi detached from forehead; it is brown and crusted on surface w/ large amounts of both fresh and old blood covering her forehead, face, and hands. Resident R [right] eye is sealed shut w/ blood w/o [without] edema. There are noted to be large	F 684		

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F 684	Continued From page 21 amounts of maggots crawling out of the lesion and point of lesion detaching from forehead...Wound cleaned...after which maggots were suctioned out of wound/lesion...no verbal or non verbal s/s [signs/symptoms] of pain noted..." Nursing documented on 5/9/23 at 5:48 a.m. that Resident #3 continued to pick at her forehead and had blood on her face and hair. On 5/9/23 at 2:06 p.m., nursing documented attempts to clean the eye and forehead lesion were unsuccessful and the NP gave an order to send the resident to the hospital for further treatment of the maggot infestation. The hospital records dated 5/9/23 documented, "...has a large right forehead skin lesion likely cancerous in nature...This large skin lesion on her forehead has been there for quite some time...within the last 24 hours staff...noticed that she had maggots in the wound...hospitalist was asked to admit given concerns about possible left facial cellulitis...She was given a one-time dose of IV [intravenous] Zosyn. Patient does indeed have maggots in the central part of her wound..." The emergency room assessment of the lesion dated 5/9/23 documented, "...Large golf ball size forehead skin lesion consistent with cancer with centralized section with some bleeding and infestation of maggots. Minimal redness in this area though periorbital area might be a little bit swollen..." The resident was admitted to the hospital and diagnosed with maggot infestation of forehead lesion and facial cellulitis. An adhesive dressing was applied after cleansing and the resident was discharged back to the facility on 5/12/23 with orders to leave the adhesive dressing in place until it naturally comes off followed by miconazole sprinkled on wound with a dressing to cover.	F 684		

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F 684	Continued From page 22 Resident #3's plan of care in place prior to the maggot infestation (revised 1/21/23) listed that the resident had a forehead skin lesion and frequently refused care to lesion, resisted activities of daily living care and most medications. Interventions to prevent complications with the lesion and minimize refusals included wound care with topical ointment, saline cleansing and TAO dressing, encouragement for resident to avoid scratching, short fingernails, good nutrition/hydration, keeping skin clean/dry, plastic surgery consult for removal of lesion, surgical consult, provision of opportunities for positive interaction/attention, encouragement to allow treatment to lesion, pain medications as ordered one half hour before treatment, explanation of procedures, and praise for improved behaviors. The care plan interventions for treatment of the lesion and care refusals prior to the maggot infestation had not been updated since 1/21/23. There were no interventions listed regarding monitoring of the lesion for signs of infection or complications until 5/9/23 after the maggot infestation. On 5/15/23 at 10:00 a.m., Resident #3 was observed in bed. The resident's forehead lesion above the right eye area was mostly covered with an adhesive tape type dressing. Where visible, the lesion was raised, had irregular shaped edges/surface and was dark red/brown in color with no signs of active bleeding. There were no maggots observed and the resident expressed no verbal or non-verbal indicators or pain or irritation. On 5/15/23 at 1:20 p.m., the registered nurse (RN #1) caring for Resident #3 was interviewed about the forehead lesion. RN #1 stated that the resident had current orders to leave the taped	F 684		

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F 684	Continued From page 23 dressing in place until it fell off. RN #1 did not know about any care orders prior to the maggot infestation on 5/9/23. On 5/15/23 at 1:30 p.m., the registered nurse assistant director of nursing (RN #2) was interviewed about Resident #3. RN #2 stated that Resident #3 had not been referred to and had not been seen by the wound consultant "because she did not have a wound." RN #2 reviewed Resident #3's clinical record and stated that prior to 5/9/23, she did not find any nursing assessments/notes about the lesion since January (2023). RN #2 stated that there were no weekly skin assessments for Resident #3 since 10/24/22. RN #2 stated that there were no orders for and therefore no prompts in the electronic record for the weekly skin checks. RN #2 stated that the facility had no designated wound nurse and any wound assessments by nursing were supposed to be documented in the clinical record if done. RN #2 reviewed Resident #3's clinical record prior to the maggot infestation and found no assessment of the forehead lesion since 11/16/22. RN #2 stated that the facility had a consultant wound physician that assessed/monitored wounds weekly and entered orders for treatments. RN #2 stated that the floor nurses were responsible for completing wound treatments as ordered. RN #2 stated that if nurses had concerns with the lesion, they were supposed to document a note, and notify the physician or NP. RN #2 stated that she did not know why Resident #3 had no wound assessments or weekly skin checks prior to identification of the maggot infestation. On 5/15/23 at 3:00 p.m., the licensed practical nurse (LPN #1) that routinely cared for Resident #3 was interviewed. LPN #1 stated that the	F 684		

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F 684	Continued From page 24 resident currently had a tape dressing on the lesion and returned from the hospital with an order to leave the tape in place. LPN #1 stated prior to the maggot infestation, there were no orders for care or treatment, and the lesion was open to air. LPN #1 stated that she thought the resident had no care orders because she "refuses everything." LPN #1 stated that she thought the wound consultant documented assessment of wounds during weekly visits. On 5/15/23 at 3:10 p.m., LPN #2 that routinely cared for Resident #3 was interviewed. LPN #2 stated Resident #3 frequently "picked" at the forehead lesion and scratched it. LPN #2 stated there were no treatment orders for the lesion. LPN #2 stated the resident scratched the lesion "every now and then" and she had placed a Band-Aid on the lesion when it was bleeding. LPN #2 stated a wound consultant came to the facility each week, but she was not sure if Resident #3 was seen by the consultant. LPN #2 stated nurses were responsible for weekly skin checks and performing any ordered wound care. On 5/15/23 at 3:35 p.m., the assistant director of nursing (RN #2) was interviewed again about any ongoing assessments, attempted treatments, or care interventions for the forehead lesion prior to 5/9/23. RN #2 stated that the resident frequently refused care/treatment but if skin assessments had been attempted, it was not documented. RN #2 stated that the last attempted medical treatment was discontinued on 1/12/23 because of ongoing refusal by the resident. RN #2 that stated consultation with a plastic surgeon resulted in a recommendation for conservative treatment and there had been no further orders for care of the lesion since 1/12/23. RN #2 stated there was no order entered for any scheduled assessment	F 684		

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F 684	Continued From page 25 of the lesion. On 5/16/23 at 8:05 a.m., the NP (other staff #8) caring for Resident #3 was interviewed about the forehead lesion with maggot infestation. The NP stated that the resident would not let anyone get near the lesion. The NP stated the resident was "constantly itching, digging in it [lesion]." The NP stated the lesion had been progressing in size since July/August 2022, at one point had a foul odor and that Resident #3 at times had blood and debris under her fingernails from scratching the area. The NP stated that she had tried anti-anxiety medications, but she did not remember when that was done. (This was attempted in August 2022 with medications discontinued on 9/13/22.) The NP stated that she was notified on 5/9/23 about maggots in the lesion and she examined and suctioned a "multitude" of maggots from the lesion after mild sedation. The NP stated that the maggots were coming out of the lesion in the area of detachment. The NP stated that she was concerned about the maggots getting into Resident #3's eyes and about the possible discomfort/pain caused by the infestation. The NP stated that four to five hours later, nursing notified her that more maggots coming from the lesion so she sent Resident #3' to the hospital for further treatment. When asked about any plan to prevent the maggot infestation, the NP stated, "I don't think there really was a plan because you could not get near her." The NP stated that she thought Resident #3 was still having the cleansing, antibiotic ointment/TAO dressing attempted and was not aware the physician (other staff #9) had discontinued the treatment and other medications on 1/12/23. The NP stated that she had not been notified by nursing of any problems and/or concerns with the forehead	F 684		

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F 684	Continued From page 26 lesion and did not realize there had been no ongoing assessments and/or monitoring of the area. When asked about a referral to the wound consultant, the NP stated that nursing usually referred residents to the wound consultant and then informed her about the referral. When asked about Resident #3's resistance to care, the NP stated that if she had her stethoscope around her neck when entering the room, Resident #3 was more likely to let her get near and perform an exam. On 5/16/23 at 8:50 a.m., the survey team met with and interviewed the administrator, director of nursing (DON), assistant director of nursing (RN #2) and the unit manager (LPN #3) about Resident #3's maggot infestation. The DON stated Resident #3's cancerous lesion "was not an open place" and stated the wound was never open. The DON stated the resident was "constantly scratching and digging" at the lesion. When asked what care was done and/or attempted for the lesion, the DON stated, "Nothing." The DON stated that there were no care orders for the lesion and the last order was for the referral to plastic surgery. The DON stated that she was not sure if there were any attempted interventions regarding the "scratching and digging" of the lesion. The unit manager (LPN #3) stated prior to the maggot infestation, there were no orders for care and that nurses left the area alone because the area was not open and the resident had already been sent for a referral. The unit manager stated that routine skin assessments were supposed to be completed weekly on all residents. The DON stated that because the lesion did not require care or measurements that nurses would only document an assessment if the area was bleeding or started coming detached. The DON	F 684		

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F 684	Continued From page 27 stated assessments were expected when there was a change. When asked if there had been changes in the lesion, the DON stated that there may have been changes in the lesion since the resident frequently scratched and picked at the area. The unit manager stated that nurses had not reported to her any concerns or problems with the lesion prior to the maggot infestation on 5/9/23. The DON was asked again about expected monitoring of the lesion. The DON stated, "It was not considered a wound." When asked what should have happened to prevent the maggot infestation, the DON stated, "If it is part of her, closed...then referral to consults was all that was needed." The DON stated that the lesion had become "bothersome" to Resident #3 because of the itching. On 5/16/23 at 9:20 a.m., the NP reported to the survey team that she had removed the partially detached tape dressing from Resident #3's forehead. The NP stated the top layer of the lesion had been removed at the hospital and the lesion was now clear of maggots. The NP stated the lesion had "some slough tissue" present, and a foul odor. The NP stated she was starting orders today for wound care that included cleansing with Betadine, miconazole sprinkles, and a dry dressing daily, in addition to liquid medication (Ativan) prior to dressing changes to minimize Resident #3's anxiety related to wound care/dressing changes. On 5/16/23 at 9:40 a.m., the physician (other staff #9) caring for Resident #3 was interviewed. The physician stated that since the referral to the plastic surgeon and the recommendation for conservative interventions, the treatment of the lesion had been "hands off" due to difficulty with the Resident #3's cooperation. The physician	F 684		

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F 684	Continued From page 28 stated that he had no recollection of any orders implemented after the antibiotic ointment and dressing was discontinued on 1/12/23. When questioned further, the physician stated that he had not been asked about attempting any anti-anxiety medications prior to treatments or dressing changes. The physician stated that he was "surprised" that the resident had not been referred to the facility's wound consultant that provided weekly assessments and treatment recommendations for wounds. The physician stated that he did not recall any communication during the past several months about any problems and or changes to Resident #3's lesion. The physician stated that the maggot infestation could not be adequately cleaned out at the facility, so Resident #3 was sent to the hospital. The physician stated that maggots only consumed necrotic, dead tissue but the infestation could lead to infection. The physician stated that infection and infestation were possible complications for any uncovered, open wound. The facility's policy titled Documentation of Wound Treatments (revised 12/1/22) documented, "The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment." This policy documented, "...Wound assessments are documented on Admission Skin Assessment upon admission, daily x 3 days, weekly using the Weekly Skin Review, and as needed if the resident or wound condition deteriorates...The following elements are documented as part of a compete wound assessment using the Pressure and Non-Pressure Wound Log...Type of wound...anatomical location...degree of skin loss if non-pressure...Measurements: height, width, depth...Description of wound	F 684		

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F 684	Continued From page 29 characteristics...Color of the wound bed...Type of tissue...Condition of the peri-wound skin...Presence, amount, and characteristics of wound drainage/exudate...Presence or absence of odor...Presence or absence of pain...Wound treatments are documented at the time of each treatment on the Treatment Administration Record...If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry, intact)...Additional documentation shall include...Date and time of wound management treatments...Weekly progress towards healing and effectiveness of current intervention...Any treatment for pain...Modifications of treatments or interventions...Notifications to physician and/or responsible party regarding wound or treatment changes..." This finding was reviewed with the administrator, director of nursing, regional nurse consultant and regional director of operations during a meeting on 5/16/23 at 2:10 p.m. The regional nurse consultant (administrative staff #3) stated at this meeting they had no other information or documentation to present regarding care of Resident #3's lesion.	F 684		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 712	1. The facility recognizes that the physician visit was untimely. Resident #3 was seen by the MD on 5/15/2023 and by the NP on 5/16/23. 2. All residents in house have the potential to be impacted by the alleged deficient practice. A Quality Monitoring review of physician visits was conducted to ensure visit compliance.	6/13/23

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F 712	Continued From page 30 §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide a physician visit every 60 days for one of fifteen residents in the survey sample (Resident #3). The findings include: Resident #3, seen by the provider on 2/10/23, did not have another physician/provider visit until eighty-seven days later on 5/9/23. Resident #3 was admitted to the facility with diagnoses that included squamous cell carcinoma on face, Alzheimer's, anemia, mood disorder, depression, blepharitis, hypothyroidism, dementia with behavioral disturbance, cellulitis, dysphagia, and chronic conjunctivitis. The minimum data set (MDS) dated 1/19/23 assessed Resident #3 with severely impaired cognitive skills. Resident #3's clinical record documented the nurse practitioner (NP) assessed the resident regarding a skin tear on 2/10/23. The was no other physician/provider visit until 5/9/23 when the resident was assessed with maggot infestation in a skin lesion. On 5/16/23 at 2:00 p.m., the regional nurse	F 712	3. The medical team was educated by the Director of Nursing regarding physician visit requirements. The physician visits will be tracked by medical records on a monthly basis. A list of visits that are due will be provided to the Director of Nursing/designee on a monthly basis who will also provide to the medical team for follow up. 4. The Director of Nursing/designee will conduct random Quality Monitoring of 10 residents to ensure compliance with physician visits weekly for 6 weeks. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/ designee.	

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F 712	Continued From page 31 consultant (administration staff #3) was asked to verify the frequency of physician visits for Resident #3. The regional nurse consultant stated that the resident should have had a physician visit in April 2023. On 5/16/23 at 2:05 p.m., the registered nurse assistant director of nursing (RN #2) was interviewed about physician visits for Resident #3. RN #2 stated that she looked and could not find any other provider visits. RN #2 stated that the NP saw Resident #3 on 2/10/23 and that Resident #3 was not seen again until 5/9/23. This finding was reviewed with the administrator, director of nursing, regional nurse consultant and regional director of operations during a meeting on 5/16/23 at 2:10 p.m. No further information was provided regarding Resident #3's physician visits.	F 712		
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;	F 842	1. The facility recognizes that the progress note for Resident #3 written by the nurse practitioner was inaccurate. Resident #3 had a new note written by the MD on 5/15 and also by the nurse practitioner on 5/16. 2. All residents in house have the potential to be impacted by the alleged deficient practice. 3. The medical team was educated by the Director of Nursing regarding the accuracy of documentation. The provider documentation system that auto-populates documentation in the	6/13/23

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F 842	Continued From page 32 (iii) Readily accessible; and (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; (iv) The results of any preadmission screening	F 842	provider notes has been adjusted to allow for provider editing. 4. The Director of Nursing/designee will conduct random Quality Monitoring of 10 residents to ensure compliance with accurate physician documentation weekly for 6 weeks. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/ designee.	

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F 842	Continued From page 33 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 staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for one of fifteen residents in the survey sample (Resident #3). The findings include: Progress notes documented by the nurse practitioner (NP) inaccurately listed medications and treatments as current when they had been previously discontinued. Resident #3 was admitted to the facility with diagnoses that included squamous cell carcinoma on face, Alzheimer's, anemia, mood disorder, depression, blepharitis, hypothyroidism, dementia with behavioral disturbance, cellulitis, dysphagia, and chronic conjunctivitis. The minimum data set (MDS) dated 1/19/23 assessed Resident #3 with severely impaired cognitive skills. Nurse practitioner progress notes dated 2/10/23 and 5/9/23 inaccurately documented the following as current medications and/or treatments for Resident #3. Neomycin-Bacitracin-Polymyxin triple antibiotic ointment, apply to forehead lesion every day and evening shift Polymyxin B-Trimethoprim solution 10000-0.1 unit/ml % to both eyes three times per day for chronic eye infection	F 842		

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F 842	Continued From page 34 Seroquel 50 mg at each bedtime for mood disorder Seroquel 12.5 mg two times per day for mood disorder Namenda 10 mg two times per day for dementia with behaviors Ergocalciferol capsule 1.25 mg each Monday and Friday for supplement Cyanocobalamin B12 fast dissolve tablet 5000 mcg each day for supplement Miralax powder 17 grams each day for constipation prevention (inaccurate on 5/9/23 note) The clinical record documented the above medications except the Miralax had been discontinued since 1/12/23 per a physician's order. The Miralax powder was discontinued on 3/1/23. Resident #3's medication administration records documented the medications were discontinued as ordered. On 5/16/23 at 8:05 a.m., the NP (other staff #8) was interviewed about the progress notes listing medications and treatments that Resident #3 was no longer receiving. The NP stated that she was not aware that the triple antibiotic ointment and other medications were discontinued by the physician on 1/12/23. The NP stated that the medication and treatment list in her notes was "computer generated" and someone would have to edit the list if changes were needed. This finding was reviewed with the administrator, director of nursing, regional nurse consultant and regional director of operations during a meeting on 5/16/23 at 2:10 p.m. No further information was provided regarding Resident #3's inaccurate progress notes.	F 842		
F 921	Safe/Functional/Sanitary/Comfortable Environ	F 921		

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F 921 SS=E	Continued From page 35 CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure a safe homelike environment on one of 4 units and in the occupational therapy room. There were missing floor tiles on the Riverside unit making the floor uneven, and uneven floor at the entrance of occupational therapy room. The Findings Include: On 5/15/23 at 12:15 PM, an observation was made of a physical therapist assisting a Resident ambulating in the hallway (on the Riverside unit) with a walker. When the Resident and the therapist (identified as other staff, OS #6) approached the missing tile in the middle of the hallway, OS #6 redirected the Resident to turn around and ambulate in another direction. On 5/16/23 at 11:20 AM, OS #6 was interviewed regarding the observation. OS #6 said that the tile had been missing for a few months and felt that it was a trip hazard and would not walk residents past the missing tile. OS #6 went on to verbalize that the entrance to the occupational room was also uneven and had seen residents using a walker almost trip when entering the room. At this time, OS #6 pointed out the entrance to the occupational room. The threshold to the room was uneven and did not have a proper	F 921	1. The floor tile on the Riverside unit has been corrected. The threshold to the entrance of the therapy room has been corrected. 2. All residents have the potential to be impacted by the alleged deficient practice. A Quality Monitoring review for all hallways/door entrances was completed focusing on missing tile and uneven door thresholds. 3. The maintenance director was educated by the Administrator regarding safe/functional/comfortable/ sanitary environment. The Maintenance Director/designee will check maintenance logs and will work thru the Tels system for routine maintenance and upkeep on a daily basis to ensure work items are being completed. 4. The Administrator/designee will conduct random Quality Monitoring reviews of each hallway and door thresholds ensuring compliance weekly for 6 weeks. The findings of the quality monitoring will be reported to the Quality Assurance/Performance	6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 36 transition strip to make the floor even. OS #6 verbalized that the floor had been that way since the new hallway flooring had been placed. On 5/16/23 at 11:30 AM, the maintenance director (other staff , OS #7) was interviewed. OS #7 said that the floor on Riverside had to be cut up due to a broken waterline in February (2023) and at the time the contractors thought that they might have to come back and do some additional work so the tile wasn't replaced. Since then, no more work had been done so the floor contractor was notified (approximately a month ago) to come out and replace the missing tile, but had not been out to the facility to work on the floor. OS #7 verbalized awareness of the uneven floor entering the occupation room and said that the floor contractor was supposed to fix it when he comes out. On 5/16/23 at 2:10 PM, the above information was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 5/16/23.	F 921	Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/ designee.	