STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495216	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted 4/10/2023- 4/13/2023. 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 this survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 4/10/23 through 4/13/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four (4) complaints were investigated during the survey. Two complaints were compliant with the regulations. Two complaints were non-compliant with the regulations, with related deficient practice cited. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 22 current resident reviews and 3 closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		5/10/23

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

Electronically Signed | 05/03/2023

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F 607	Continued From page 1 §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review, and facility document review, the facility staff failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property as evidenced by failure to pre-screen 2 of 25 new hire employees #22 and #25. Both employees were agency Certified Nursing Assistants (CNAs). The findings included: The facility staff failed to obtain reference checks per their policy for two agency employees #22 and #25. A review of employee records revealed the	F 607	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F607 1. Reference checks were completed on agency staff members #22 and #25 on 4/13/20 2. Audit of current agency employees will be completed on or before 5/10/2023 by	

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F 607	Continued From page 2 following. New hire #22 (agency) hire date 01/24/23 employee file did not include any reference checks. This staff last worked at the facility in 02/17/23. New hire #25 (agency) hire date 02/03/23 employee file did not include any reference checks. This staff last worked at the facility on 03/31/23. The facility provided the survey team with a copy of their policy titled, "Prevention/Screening/Training." This policy read in part, "...Criminal background and reference checks are performed on all employees..." 04/12/23 4:00 p.m., Director of Nursing (DON) stated they were unable to obtain reference checks on these 2 employees from the agency. 04/12/23 4:14 p.m., during an end of the day meeting with the Administrator, DON, and Regional Nurse Consultant the issue regarding the missing reference checks was reviewed. Prior to the exit conference on 04/13/23 the DON provided the surveyor with reference checks obtained on these two employees by the facility. These documents were dated 04/13/23.	F 607	Human Resource Manager/designee. 3. Education will be provided to Human Resource Manager regarding checking to ensure agency staff have references. 4. Human Resource Manager or Designee will audit agency staff member files weekly for 2 months to ensure references are obtained. 5. Date of completion: 5/10/2023	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		5/10/23

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F 684	Continued From page 3 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident representative interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the residents receive care in accordance with the comprehensive person-centered care plan and/or medical provider orders for 2 of 25 residents in the survey sample, Residents #25 and #264. The findings included: 1. For Resident #25, the facility staff failed to perform a hemoccult test to detect the presence of occult blood in the stool according to the medical provider's direction. Resident #25's diagnosis list indicated diagnoses, which included, but not limited to Fibromyalgia, Chronic Obstructive Pulmonary Disease, History of Venous Thrombosis and Embolism, Peripheral Vascular Disease, and Alzheimer's Disease. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/04/23 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. Resident #25's current comprehensive person-centered care plan included a focus area stating in part " ...the resident is at risk for bleeding, hemorrhage, excessive bruising and	F 684	F684 1. NP was made aware on 4/11/2023 that hemoccult for resident #23 was not obtained. Resident #264 is no longer at the facility. Resident #75 oxygen was corrected and administered per order on 4/11/2023 and the NP was made aware on 4/11/2023 . 2. Audit of current residents on Trulicity will be completed to ensure medication is administered per physician□s order before 5/10/23. 3. DON/Unit Manager or Designee will audit residents' EMAR to ensure Trulicity is being administer per physician□s orders 1x weekly for 2 months. Any noncompliance will result in education and or corrective action and reported to the physician. Results of the audit will also be reviewed in QA. 4. Audit of provider progress notes on current residents will be completed on or before 5/10/2023 for the past 30 days to ensure that any medication orders were transcribed into the EMAR system. 5. Providers (NP, MD) will receive education from DON/SDC/Designee regarding the procedure for transcribing	

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F 684	Continued From page 4 complications related to anticoagulant use secondary to: history of DVT [deep vein thrombosis], AFib [atrial fibrillation]" with an intervention dated 11/21/22 for labs as ordered. According to Resident #25's clinical record, the resident was seen by the nurse practitioner (NP) on 2/21/23, the progress note stated in part " ...The patient is seen at the request of nursing staff due to long history of diarrhea which is increasing recently [sic] nursing staff describes stools as dark, very loose, and having a foul odor ...Obtain Hemoccult ..." Resident #25 was again seen by the NP on 3/02/23, the progress noted stated in part " ...The patient is seen for reviewing of labs. CBC [complete blood count] which shows WBC [white blood count] 8.2, hemoglobin is 7.7, hematocrit 24.7, platelets 382. Last hemoglobin and hematocrit on 1/24 [1/24/23] were 10.6 and 33.8. Review of medication show the patient is on Eliquis 5 mg twice a day ...If hemoglobin remains less than 8, we will type and crossmatch for 2 units as well as discontinue anticoagulant. Patient had a hemocult [sic] ordered last week where no results are seen, therefore, we will reorder today ..." Resident #25's clinical record included a 3/03/23 5:19 pm progress note documenting the results of the hemoccult test as positive indicating the presence of occult blood in the resident's stool. Surveyor reviewed Resident #25's clinical record and was unable to locate hemoccult results prior to 3/03/23. On 4/11/23 at 9:58 am, surveyor spoke with	F 684	orders into PCC by 5/10/2023. 6. Date of completion: 5/10/2023	

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F 684	Continued From page 5	F 684		

licensed practical nurse (LPN) #3 who stated Resident #25's hemoccult was obtained on 3/03/23 and that was the only one obtained. LPN #3 stated there was no order entered into the resident's record for a hemoccult following the NP's visit on 2/21/23. LPN #3 further stated it was unclear what happened, and it was the NP's first week at the facility.

On 4/12/23 at 11:10 am, surveyor spoke with the NP who stated when they returned the following week, they noticed the hemoccult was not done and asked for it to be done again. NP stated they did not ask the reason why the hemoccult was not obtained as ordered. NP stated lab orders are given by verbal orders and all other orders are entered into the system at the time of the order. Surveyor asked if a hemoccult was a lab order and the NP stated yes. When asked if the delay in obtaining the hemoccult impacted Resident #25's outcome, the NP stated no, and they were continuing to monitor their CBCs, and the resident has an upcoming GI (gastrointestinal) consult appointment.

On 4/12/23 at 4:14 pm, the survey team met with the interim administrator, director of nursing (DON), and the regional director of clinical services and discussed the concern of staff failing to perform a hemoccult test for Resident #25 as ordered by the physician.

On 4/13/23 at 10:48 am, the DON stated lab tests performed by the lab company are given by verbal order and hemoccult tests are performed onsite therefore the provider enters the order themselves.

No further information regarding this concern was

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F 684	Continued From page 6	F 684		

presented to the survey team prior to the exit conference on 4/13/23.

2. For Resident #264 the facility staff failed to administer the antidiabetic medication, Trulicity, as ordered by the physician.

Resident #264's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus.

Resident #264's most recent minimum data set with an assessment reference date of 02/10/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicated that the resident was cognitively intact.

Resident #264's comprehensive care plan was reviewed and contained a care plan for "the resident is at risk for complications blood glucose fluctuations related to diagnosis of diabetes mellitus with: insulin use." Interventions for this care plan included "administer medications as ordered."

Resident #264's physician's orders were reviewed and contained orders, which read in part "Trulicity Solution Pen-injector 0.75 mg/0.5 ml (Dulaglutide). Inject 0.5 ml subcutaneously one time a day every Mon for DM2(diabetes mellitus 2). Order date 11/26/22, D/C (discontinued date) 12/12/22", "Trulicity Solution Pen-injector 0.75 mg/0.5 ml (Dulaglutide). Inject 0.5 ml subcutaneously one time a day every Tue for DM. Order date 12/12/22, D/C date 12/22/22.", "Trulicity Solution Pen-injector 0.75 mg/0.5 ml (Dulaglutide). Inject 0.5 ml subcutaneously one time a day every Tue for DM. Order date

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F 684	Continued From page 7	F 684		

12/26/22, D/C date 01/16/23.", "Trulicity Solution Pen-injector 0.75 mg/0.5 ml (Dulaglutide). Inject 0.5 ml subcutaneously one time a day every Fri for DM. Order date 01/16/23, D/C date 02/07/23", and "Dulaglutide Subcutaneous Solution Pen-injector 0.75 mg/0.5 ml (Dulaglutide). Inject 0.75 mg subcutaneously one time a day every Tue for DM. Order Date 02/07/23."

Resident #264's medication administration records (MAR) for the months of November and December 2022, January, February, and March 2023 were reviewed and contained orders as above. The December MAR was coded "5" on 12/12/22 and "9" on 12/13/23. The January MAR was coded "9" on 01/10/23. The February MAR was coded "5" on 02/21/23. Chart code "5" is equivalent to "Hold/see nurses notes". Chart code "9" is equivalent to "Other/see nurses notes".

Resident #264's nurse's progress notes were reviewed and contained notes which read in part, "12/12/2022 10:31 Note Text: Trulicity SolutionPen-injector 0.75 mg/0.5 ml. Inject 0.5 ml subcutaneously one time a day every Mon for DM2. due 12/13", "12/13/2022 07:46 Note Text: held per md orders", "01/10/2023 10:30 Note Text: not available re-ordered from pharmacy", and "02/21/2023 09:26 Note Text: on order awaiting pharmacy."

Surveyor spoke with pharmacy technician on 04/12/23 at 11:35 am regarding Resident #254's Trulicity order. Surveyor asked pharmacy technician how often they sent the Trulicity and pharmacy technician stated that they sent it when they got a refill request, and each refill was one administration. Pharmacy technician stated that the Trulicity was refilled a total of 9 times while

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F 684	Continued From page 8	F 684		

the resident was at the facility. For the duration the resident's stay at the facility, they should have received a total of 15 administrations of Trulicity.

The concern of not administering the resident's Trulicity per the physician's orders was discussed with the administrator, director of nursing and regional director of clinical services on 04/15/23 at 10:50 am. No further information provided prior to exit.

Resident #264's blood pressure documentation was reviewed. Abnormal blood pressures were documented for 1/5/23. On 1/5/23 at 9:17 a.m., Resident #264's blood pressure was documented as 208/82. On 1/5/23 at 13:22 a.m., Resident #264's blood pressure was documented as 206/90.

Resident #264's clinical record included a provider note dated 1/5/23; this provider note was completed by Staff Member (SM) #4 (a nurse practitioner). This 1/5/23 note indicated the medication amlodipine (5mg) was to be started and proved daily. No evidence was found to indicate this medication had been started. On 4/13/23 at 10:40 a.m., SM #4 was asked about why the amlodipine was not started. SM #4 reported they expected the medication to have been provided. SM #4 stated they would have given the order, to be entered into the computerized medical records, by the facility's nursing staff. SM #4 stated they would have provided the order verbally or written to the facility's nursing staff. (SM #4 stated when written orders are provided to staff to be entered into the computerized record, the page the order is written on is not maintained as part of

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F 684	Continued From page 9 residents' clinical record.) On 4/12/23 at 4:14 p.m., the survey team met with the facility's Administrator, DON, and Regional Director of Clinical Services. Resident #264's clinical record not containing evidence the amlodipine order had been entered into the computerized order system was discussed. No evidence Resident #264 had received the amlodipine, based on the 1/5/23 medical provider progress note, was discussed. No additional information related to this issue was provided to the survey team. (Amlodipine is a medication used to treat high blood pressure.)	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide respiratory care consistent with the comprehensive person-centered care plan and physician's orders for 1 of 25 residents in the survey sample, Resident #75. The findings included:	F 695	F695 1. NP was made aware of oxygen being administered at 3 LPM for resident # 75. Oxygen was corrected by Unit Manager at the time it was observed. 2. Audit of current residents receiving oxygen will be completed by 5/10/2023 to ensure oxygen is being administered per	5/10/23

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F 695	Continued From page 10 For Resident #75, the facility staff failed to administer oxygen as ordered by the physician. Resident #75's diagnosis list indicated diagnoses, which included, but not limited to Nonrheumatic Aortic Insufficiency, Paroxysmal Atrial Fibrillation, Obstructive Sleep Apnea, Dependence on Supplemental Oxygen, Chronic Kidney Disease, Morbid Obesity, Dementia, and Type 2 Diabetes Mellitus. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/03/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #75 was coded as requiring extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident was also coded as receiving oxygen therapy within the last 14 days. On 4/11/23 at 11:11 am, surveyor observed Resident #75 in bed receiving oxygen via nasal cannula at the delivery rate of 3.5 liters per minute (L/M) per the oxygen concentrator setting. The concentrator was located on the right side, at the head of the bed out of the resident's reach. Resident #75 asked what setting the concentrator was on and surveyor informed the resident the concentrator was set at 3.5 L/M. Resident #75 stated "I don't think it's supposed to be that much" and asked surveyor to have it checked. Surveyor immediately notified licensed practical nurse (LPN) #3 who stated she would check the oxygen setting. Later in the day on 4/11/23, surveyor observed Resident #75 in bed receiving oxygen via nasal cannula at 2 L/M.	F 695	physician orders. 3. DON/ADON/Unit Manager or designee will audit residents receiving oxygen 2-3x weekly for 2 months to ensure oxygen is being administered per physician□s order. 4. SDC/Designee will provide education to current licensed staff members regarding following physician□s orders for oxygen administration by 5/10/2023. 5. Date of completion: 5/10/2023	

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F 695	Continued From page 11 Resident #75's current physician's orders included an order dated 4/05/23 for oxygen at 2 L/M via nasal cannula for shortness of breath. Resident #75's current comprehensive person-centered care plan included an intervention dated 9/29/22 to administer oxygen as ordered. Surveyor reviewed Resident #75's April 2023 Treatment Administration Record (TAR) and the administration of oxygen at 2 L/M via nasal cannula was initialed by the nurse for 4/11/23 dayshift. Surveyor requested and received the facility policy entitled "Respiratory/Oxygen Equipment" which read in part "Licensed staff will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per provider's order and in accordance with standards of practice ..." On 4/11/23 at 4:32 pm, the survey team met with the interim administrator, director of nursing, and regional director of clinical services and discussed the concern of Resident #75 receiving oxygen at the rate of 3.5 L/M instead of the ordered rate of 2 L/M. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/23.	F 695		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		5/10/23

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F 760	Continued From page 12 medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents were free of significant medication errors for 2 of 25 residents in the survey sample, Residents #75 and #30. The findings included: 1. For Resident #75, the facility staff failed to administer Novolin 70/30 as ordered by the medical provider. Novolin 70/30 is an intermediate acting insulin used to control blood sugar. Resident #75's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Nonrheumatic Aortic Insufficiency, Paroxysmal Atrial Fibrillation, Obstructive Sleep Apnea, Chronic Kidney Disease, and Morbid Obesity. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/03/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #75's current physician's orders included active orders for Novolin 70/30 10 units subcutaneously in the morning and hold if blood sugar was less than 150 and Novolin 70/30 15 units subcutaneously in the evening and hold if blood sugar less than 150. The morning Novolin 70/30 was scheduled for administration at 9:00 am and the evening dose was scheduled at 6:00	F 760	F760 1. Resident #75 accu check and insulin orders were reviewed by the NP on 4/12/2023 with new orders obtained to obtain accu checks times. Resident #30 NP was made aware that Humalog was held on 4/12/2023. 2. SDC/Designee will provide education to current licensed nurses by 5/10/2023 in regards to time frames to obtain accu checks. 3. DON/ADON/Unit managers/ Designee will audit current residents to ensure accu check order time frames are appropriate with insulin administration orders 2-3x weekly x 2 months. 4. DON/ADON/Unit managers/ Designee will complete audit on current residents receiving Humalog insulin to ensure physician□s orders are followed by 5/10/2023. 5. DON/ADON/Unit Manager/designee will audit current residents receiving Humalog to ensure medication is being administered per physician□s orders 2-3x weekly for 2 months. 6. SDC/Designee will educate licensed nurses by 5/10/2023 to obtain a physician□s order before holding Humalog insulin.	

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F 760	Continued From page 13 pm. Surveyor reviewed Resident #75's clinical record and was unable to locate documentation of the resident's blood sugars prior to Novolin 70/30 administration on the following occasions: 4/06/23 9:00 am, 4/07/23 9:00 am, 4/08/23 9:00 am, 4/10/23 6:00 pm, and 4/11/23 9:00 am. According to Resident #75's April 2023 Medication Administration Record (MAR), Novolin 70/30 15 units was not administered on 4/06/23 at 6:00 pm, as the MAR was left blank, surveyor was unable to locate a corresponding blood sugar for this administration. Resident #75's current comprehensive person-centered care plan included a focus area stating in part " ...The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus with: insulin use" with an intervention dated 10/10/22 to administer insulin as ordered. On 4/11/23 at 4:32 pm, the survey team met with the interim administrator, director of nursing, and regional director of clinical services and discussed the concern of staff failing to administer Novolin 70/30 according to physician's orders. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/23. 2. For Resident #30 the facility staff failed to administer insulin per the physician's order. Resident #30's face sheet listed diagnoses which included but not limited to type 2 diabetes	F 760	7. Date of completion: 5/10/2023	

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F 760	Continued From page 14	F 760		

mellitus.
The most recent minimum data set with an assessment reference date of 01/16/23 assigned the resident a brief interview for mental status score of 12 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #30's comprehensive care plan was reviewed and contained a care plan for "Diabetes Mellitus: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus with: insulin use." Interventions for this care plan included "administer insulin as ordered."

Resident #30's clinical record was reviewed and contained a physician's order summary for the month on April 2023, which read in part "Humalog KwikPen Solution Pen-injector 100 unit/ml (Insulin Lispro (1 Unit Dial)) Inject 5 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLY NEUROPATHY (E11.42)" and "Humalog KwikPen Solution Pen-injector 100 unit/ml (Insulin Lispro (1Unit Dial)) Inject 8 unit subcutaneously one time a day related to DIABETES MELLITUS WITH DIABETIC POLY NEUROMPATHY (E11.42)."

Resident #30's medication administration record for the month of April 2023 was reviewed and contained entries as above. The entry for Humalog 5 units with meals was coded "5" on 04/09/23 at 12 pm, which is equivalent to "Hold/see progress notes."

Resident #30's nurse's progress notes were reviewed and contained a progress note dated 04/09/23, which read in part "pt (patient) BS

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F 760	Continued From page 15 (blood sugar) was 128 at 1130 and he/she was given 8 units. Second 5 units was held due to BS." Surveyor spoke with director of nursing (DON) on 04/12/23 at 10:20 am regarding Resident #30's insulin. Surveyor asked DON to review resident's physician's order summary and medication administration record. DON confirmed that insulin was not administered as ordered. Surveyor asked if insulin should have been held, and DON stated, "Not without calling the physician and getting an order to hold. I will start education immediately." The concern of holding the resident's insulin without a physician's order was discussed with the administrator, DON, and regional director of clinical services on 04/12/23 at 4:15 pm. No further information was provided prior to exit.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide laboratory services to meet the needs of the resident for 1 of 25 residents, Resident #94.	F 770	F770 1. NP was made aware resident #94 TSH and LFT was not obtained per MD order on 4/12/2023.	5/10/23

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F 770	Continued From page 16 The findings included: For Resident #94, the facility staff failed to obtain the provider ordered labs TSH (thyroid stimulating hormone) and LFT (liver function test). Resident #94's diagnosis included, but were not limited to, adult failure to thrive, hyperlipidemia, and chronic kidney disease. Section C (cognitive patterns) of Resident #94's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 02/15/23 included a brief interview for mental status (BIMS) summary score of 11 out of a possible 15 points. Resident #94's clinical record included a pharmacy recommendation dated 01/16/23 for a LFT and TSH due to the residents Amiodarone therapy. 02/08/23, Family Nurse Practitioner ordered LFT and TSH laboratory tests due to Amiodarone therapy. During the clinical record review, the surveyor was unable to locate any results for the ordered laboratory tests. 04/11/23 11:20 a.m., Unit Manager stated they were unable to find any evidence that the laboratory tests were obtained. 04/12/23 4:14 p.m., the Administrator, Director of Nursing, and Regional Nurse Consultant were made aware of the missing laboratory tests.	F 770	2. SDC/Designee will educate current licensed nurses regarding obtaining of labs per MD orders by 5/10/2023. 3. DON/ADON/Unit Managers will complete audit on current in house residents with orders for LFT and TSH in the past 90 days to ensure completion per MD orders by 5/10/2023. 4. DON/ADON/Unit Manager/Designee will audit current residents' orders 2-3x weekly for 2 months to ensure TSH and LFT are obtained per MD orders. 5. Date of completion: 5/10/2023	

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F 770	Continued From page 17 No further information regarding the missing laboratory tests was provided to the survey team prior to the exit conference.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (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	F 842		5/10/23

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F 842	Continued From page 18 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed 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 interviews, clinical record review, and facility document review, the facility staff failed to maintain a complete and accurate clinical record for one (1) of 25 residents (Resident #100). The findings include:	F 842	F842 1. Resident #100 diagnosis was corrected on 4/12/2023 by MDS Coordinator to include Acute Renal failure and ESRD was struck out due to data entry error.	

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F 842	Continued From page 19 Resident #100's clinical record included a list of diagnoses. End Stage Renal Disease (ESRD) was incorrectly listed as one of Resident #100's diagnoses. No medical provider documentation was found to support the diagnosis of ESRD. Resident #100's Minimum Data Set (MDS) assessment, with an Assessment Reference date (ARD) of 2/26/23, was dated as completed on 3/4/23. Resident #100 was assessed as able to make self understood and as able to understand others. Resident #100's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition. Resident #100 was assessed as requiring assistance with bed mobility, transfers, toilet use, and personal hygiene. Resident #100 discharge documentation, from a local hospital, included the medical problem of Acute Renal Failure. This discharge document was dated 2/20/23 at 2:12 p.m. On 4/12/23 at 11:15 a.m., Staff Member (SM) #1 (a nurse practitioner) reviewed Resident #100 clinical documentation. SM #1 confirmed Resident #100 had the diagnosis of Acute Renal Failure; SM #1 stated they were hopeful for Resident #100's kidney function to return. On 4/12/23 at 11:20 a.m., the surveyor discussed, with the facility's Director of Nursing (DON) and Regional Director of Clinical Services, Resident #100's diagnoses list containing the incorrect renal disease diagnosis. The following information was obtained from a	F 842	2. Audit was completed of current residents with diagnosis of Acute Renal Failure to ensure diagnosis were correct on 4/12/2023 by MDS Coordinator. 3. Education will be given to MDS coordinators by 5/10/2023 by Administrator or Designee regarding coding of correct diagnosis. 4. MDS coordinator/designee will audit diagnosis codes for residents with renal failure to ensure appropriate diagnosis is coded 1x week for 2 months. 5. Date of completion: 5/10/2023	

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F 842	Continued From page 20 policy named "Documentation Summary" (with an effective date of 11/1/19): "Document all of the facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviations from standard treatment along with the reason for the deviation." On the afternoon of 4/12/23, Resident #100's clinical documentation was reviewed. It was noted the diagnosis of ESRD had been "struck out" due to a "data entry error". On 4/12/23 at 4:14 p.m., the survey team met with the facility's Administrator, DON, and Regional Director of Clinical Services. Resident #100 having the diagnosis of ESRD documented when the resident was experiencing Acute Renal Failure was discussed.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		5/10/23

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F 880	Continued From page 21 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 22 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and during the course of a medication pass and pour observation, the facility staff failed to maintain an infection prevention and control program to provide a safe, sanitary environment to help prevent the development and transmission of communicable disease and infections on one of two facility units, unit 1. The findings include: During a medication pass and pour observation, Licensed Practical Nurse (LPN) #1 failed to change gloves and perform hand hygiene after administering eye drops to resident #9. On 4/11/23 at 08:39 AM surveyor observed LPN #1 during a medication pass and pour observation administer Artificial Tears eye drops to resident #9. After administering the eye drops, LPN #1 gave the resident their pills by using their fingers to pick each pill out of the medication cup individually, place the pill onto a spoon with pudding then put in the resident's mouth. LPN #1 did not change their gloves or perform hand hygiene after administering the eye drops. Surveyor asked LPN #1 what the facility policy was for hand hygiene when administering eye drops, they stated, "I should have changed my	F 880	F880 1. LPN #1 received education in regard to removing gloves and performing hand hygiene after administration of eye drops on 4/11/2023 2. SDC/Designee will provide education to current licensed staff by 5/10/2023 regarding removing gloves and hand hygiene after administration of eye drops. 3. SDC/Unit Managers/Designee will audit the administration of resident eye drops 2-3 x weekly on 3-4 residents to ensure proper hand hygiene is occurring for 2 months. 4. Date of completion: 5/10/2023	

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F 880	Continued From page 23	F 880		

gloves before I gave the pills".

Surveyor requested and received the policy entitled, "Handwashing Requirements", with an effective date of 2/6/20. The policy read in part, Under Section A. Hand Hygiene "The following is a list of some situations that require hand hygiene", Under section k. "Upon and after coming into contact with a patient's intact skin", and Under Section D. Gloves, "Remove gloves after caring for a patient", and "Change gloves during patient care when moving from a contaminated body site to a clean body site".

Surveyor also received the Pharmscript policy with a revision date of 8/2020 entitled, "Administration Procedures for all Medications", which read in part under IV. Administration #3. "Cleanse hands using antimicrobial soap and water or facility- approved hand sanitizer before beginning a med pass, before handing medication and before contact with a resident".

The survey team met with the Administrator, Director of Nursing and Regional Nurse Consultant on 4/11/23 at 4:30 PM and discuss this concern.

No further information was provided to the survey team prior to exit on 4/13/23.