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	495233	A. BUILDING _____ B. WING _____	C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAUQUIER HEALTH REHABILITATION & NURSING CENTER	**360 HOSPITAL DRIVE WARRENTON, VA 20186**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/31/2023 through 08/02/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/31/23 through 08/02/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint (VA00059280:-substantiated with deficiency) was investigated during the survey. The census in this 113 certified bed facility was 38 at the time of the survey. The survey sample consisted of 22 resident reviews.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		8/25/23

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

Electronically Signed | 08/17/2023

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F 656	Continued From page 1 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for four of 22 residents in the survey sample, Residents #38, #39, #242 and #35.	F 656	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 656	Continued From page 2 The findings include: 1. For Resident #38, the facility staff failed to implement the comprehensive care plan for administering pain medications per the physician orders. The comprehensive care plan dated, 5/27/2023 documented in part, "Focus: (R38) is at risk for acute pain due to her osteoarthritis, limited ROM (range of motion) to her neck and kidney stones." The "Interventions" documented in part, "Pain patches to neck and knee per MD (medical doctor) order." Observation was made of RN (registered nurse) #3, administering medications on 8/1/2023 at 8:42 a.m. to R38. RN #3 prepared the medications. She pulled out two Aspercreme Pad Lido (lidocaine) 4% pads. One was for the resident's neck, and one was for the resident's left knee. RN #3 entered the room and administered the oral medications. She then placed one of the Aspercreme Pads to the back of the resident's neck. She proceeded to the other side of the bed and pulled back the covers off the resident's left knee. The Aspercreme pad was still on the resident's left knee, dated 7/31/2023. RN #3 stated she could not just remove the patch and apply the new one as there was an order to remove it after 12 hours of being on. RN #3 went and spoke with the unit manager and left a message for the nurse practitioner. The physician orders dated, 7/17/2023, documented, "Lidocaine External Patch 4% (Lidocaine) (1), Apply to L (left) knee topically one time a day for OA (osteoarthritis) and remove per	F 656	Resident #38 pain medication orders have been reviewed and medical record documents accurate administration of pain medications in accordance with the physician orders. No policy changes were made. Unable to update care plan related to side rails for resident #39 due to discharge on 8/3/2023. Correction of deficiency occurred 8/2/2023 with placement of the fall mat on resident #242□s left side of bed while resident is in bed as per physician order. Corrected deficient practice for Resident #35 bagged lunch for off-site dialysis was corrected on 8/2/2023. Comprehensive care plan for dialysis care, specifically related to offering food prior to dialysis was updated on 8/2/2023. All residents in the facility have the potential to be affected. All nursing staff will be educated on care plan process and requirement to implement care plan interventions. Nurse manager or designee will audit 25% of resident care plans with pain medication, side rails, fall mats, and dialysis. Weekly x□s four (4) weeks then monthly x□s three (3). Results of audit findings will be reviewed for patterns and/or trends and a summary	

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F 656	Continued From page 3 schedule." The July 2023 MAR (medication administration record) documented the above order. The Lidocaine External Patch was to be applied at 9:00 a.m. and removed at 2059 (8:59 p.m.). An interview was conducted with LPN #2, the unit manager, on 8/2/2023 at 8:33 a.m. When asked the purpose of the care plan, LPN #2 stated, "It's their life, their plan of care." LPN #2 was asked if it should be followed, LPN #2 stated, yes. When asked who is responsible for implementing the care plan, LPN #2 stated, it's everyone that is responsible for implementing the care plan. The facility policy, "Baseline Care Assessment and Comprehensive Care Plan," documented in part, "6. The interdisciplinary team, in conjunction with the resident, resident's family, surrogate or representative should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment ...7. The care plan must describe the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment ...11. The care plan includes treatment objective that have measurable outcomes with timetables and specific approaches to meet the defined needs." The policy did not address the implementation of the care plan. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM # 4, the vice president of post-acute services, were made aware of the above concern	F 656	of the audits will be provided at the monthly QAPI meeting.	

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F 656	Continued From page 4 on 8/2/2023 at 9:58 a.m.	F 656		

No further information was provided prior to exit.

2. For Resident #39 (R39), the facility staff failed to develop a care plan for the use of side rails.

Observation was made of R39 on 8/1/2023 at 8:21 a.m. The resident was in bed, with both side rails up.

The "Side Rail and Entrapment Evaluation" dated 7/6/2023 documented in part, "Resident's care plan addresses use of side rails and interventions to minimize injury or entrapment." A "Y," indicating, yes, was documented.

The comprehensive care plan dated, 7/7/2023, failed to evidence documentation for the use of side rails.

An interview was conducted with LPN #2, the unit manager, on 8/2/2023 at 8:33 a.m. When asked the purpose of the care plan, LPN #2 stated, "It's their life, their plan of care." LPN #2 was asked if it should be followed, LPN #2 stated, yes. When asked who is responsible for implementing the care plan, LPN #2 stated, it's everyone that is responsible for implementing the care plan. When asked if a resident uses side rails, should that be on the care plan, LPN #2 stated, yes, and after reviewing R39's care plan LPN #2 stated she didn't see the use of side rails on the care plan.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM # 4, the vice president of post-acute services, were made aware of the above concern

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F 656	Continued From page 5 on 8/2/2023 at 9:58 a.m.	F 656		

No further information was provided prior to exit.
3. For Resident #242 (R242), the facility staff failed to implement the care plan to place a fall mat on the floor to the left side of the bed while he was lying in bed.

R242 was admitted to the facility with a diagnosis that included but was not limited to convulsion (1).

R242's admission MDS (minimum data set) was not due at the time of the survey.

The facility's admission assessment for R242 dated 07/24/2023 documented in part, "Mental Status: Alert & (and) Oriented x3 (times three - person, place, time)."

On 08/01/23 at approximately 1:30 p.m., R242 was observed lying in bed asleep. Further observation failed to evidence a fall mat on the floor next to the bed.

On 08/01/23 at approximately 3:20 p.m., R242 was observed lying in bed asleep. Further observation failed to evidence a fall mat on the floor next to the bed.

The physician's order for R242 documented in part, "Fall mat in place to left side of bed when resident is in bed. Order Date: 07/31/2023."

The comprehensive care plan for R242 documented in part, "Focus. (R242) is at risk for falls characterized by history of falls, CVA (cerebral vascular accident) with left sided weakness related to: impaired balance, poor

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F 656	Continued From page 6	F 656		

coordination. Date Initiated: 07/24/2023." Under "Interventions" it documented in part, "Fall mat in place to left side of bed when resident is in bed Date Initiated: 07/31/202."

On 08/02/23 at approximately 8:33 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked to describe the purpose of a resident's care plan she stated that it is the resident's life, the resident's plan of care. After reviewing R242's care plan for the use of the fall mat and informed of the above observations, she was asked if the care plan was being followed. LPN #2 stated no.

On 08/02/2023 at approximately 9:40 a.m., ASM (administrative staff member) #2, administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: Seizures | MedlinePlus.

4. For Resident #35, the facility staff failed to implement the comprehensive care plan for dialysis care, specifically offering food prior to dialysis.

Resident #35 was admitted with diagnosis that included but not limited to: ESRD (end stage renal disease).

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F 656	Continued From page 7	F 656		

Resident #35's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/7/23, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of MDS Section O-Special Procedures: coded the resident as dialysis-yes.

A review of the comprehensive care plan dated 12/12/19 and revised on 6/30/23, revealed, "FOCUS: Resident has end stage renal disease and receives hemodialysis via left arm AV (arterio-venous) graft, 3 times a week on Monday, Wednesday and Friday. Resident is at increased nutritional risk related to requiring a therapeutic diet, food preferences for foods that contradict diet order, ESRD on hemodialysis, Heart Failure and Type 2 diabetes mellitus. Resident has nutritional risk related to related to heel pressure injury. INTERVENTIONS: Prepare and send meal with (Name) as well as any other items he may need. Encourage to follow ordered diet to reduce risks of fluid overload/deficit and nutritional concerns. Revised 6/17/20: Dialysis no longer allows resident to take food into the center. Resident usually has a big breakfast each morning, monitor for the need to offer food prior to going out at 10 am and immediately upon returning from dialysis. Revised on 10/13/20: Currently foods are not allowed at dialysis due to COVID precautions. Provide snacks upon return as requested. Revised 6/30/23: Educate Resident / Representative regarding nutritional needs and requirements. Offer Juven supplement twice daily to promote wound healing."

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A review of the physician's order dated 1/20/22, revealed, "Dialysis every Mon-Wed-Fri at 11:00am pick up at 10:30am."

An interview was conducted on 7/31/23 at approximately 10:00 AM, with Resident #35. Resident #35 was sitting in a wheelchair in his room, waiting for dialysis transport. When asked if he had a bagged lunch from the facility or if food was provided by the dialysis center, Resident #35 stated, "No, they do not give us food at the dialysis center. I have only been given lunch from this place once. Two sandwiches, since then no food. I do not get back till close to supper time and I have missed my lunch completely." Inside the resident's dialysis bag were one bag of hard candy and one bag of gummy candy. When asked about the candy, Resident #35 stated, "That is all I have to take to eat during dialysis."

An interview was conducted on 8/2/23 at 8:40 AM, with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, it is their life and it is used to identify a plan of care, it should be followed. When asked who is responsible for implementing the care plan, LPN #2 stated, any aspect of the care plan is to be implemented by the nurse, aides and the interdisciplinary team. When asked if the care plan had been followed regarding Resident #35's nutrition related to dialysis, LPN #2 stated, no, it has not been implemented. We are sending a bag lunch with him today and will revise the care plan today.

On 8/1/23 at approximately 4:15 PM, ASM (administrative staff member) #1, the administrator, and ASM #2, the director of

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F 656	Continued From page 9 nursing was made aware of the findings. According to the facility's "Baseline Care Assessment and Comprehensive Care Plan" policy, "The care plan must describe the services that are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well being in accordance with the comprehensive assessment." No further information was provided prior to exit.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to administer medications per the physician order for one of 22 residents in the survey sample, Resident #38. The findings include: For Resident #38 (R38), the facility staff failed to remove a lidocaine patch per the physician orders. Observation was made of RN (registered nurse) #3, administering medications on 8/1/2023 at 8:42 a.m. to R38. RN #3 prepared the medications. She pulled out two Aspercreme Pad	F 658	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law. Resident #38 pain medication orders have been reviewed and medical record documents accurate administration of pain medications in accordance with the physician orders. No policy changes were made. All residents have the potential to be impacted by this deficient practice.	8/25/23

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F 658	Continued From page 10 Lido (lidocaine) 4% pads. One was for the resident's neck, and one was for the resident's left knee. RN #3 entered the room and administered the oral medications. She then placed one of the Aspercreme Pads to the back of the resident's neck. She proceeded to the other side of the bed and pulled back the covers off the resident's left knee. The Aspercreme pad was still on the resident's left knee, dated 7/31/2023. RN #3 stated she could not just remove the patch and apply the new one as there was an order to remove it after 12 hours of being on. RN #3 went and spoke with the unit manager and left a message for the nurse practitioner. The physician orders dated, 7/17/2023, documented, "Lidocaine External Patch 4% (Lidocaine) (1), Apply to L (left) knee topically one time a day for OA (osteoarthritis) and remove per schedule." The July 2023 MAR (medication administration record) documented the above order. The Lidocaine External Patch was to be applied at 9:00 a.m. and removed at 2059 (8:59 p.m.). An interview was conducted on 8/1/2023 at 3:38 p.m. with LPN (licensed practical nurse) #2, the unit manager. When asked the process for applying and removing a Lidocaine patch, LPN #2 stated they are applied in the mornings and removed after 12 hours. LPN #2 was asked why is that done that way, LPN #2 stated it's per the physician orders and to prevent irritation of the skin where the patch was applied. When asked if it is signed off as removed on the evening shift and the day shift nurse finds it still in place the next morning, is that following the physician orders, LPN #2 stated, no.	F 658	LPN #4 was educated on the importance of following physician orders as written with each medication administration. Procedures will be performed prior to signing off on the MAR or TAR. Review of the medication administration policy & procedure and what are medication errors & how to prevent them. All staff were educated on the importance of following physician orders involving medications and the accurate documentation of administration will be performed. Unit manager or designee will perform medication pass audits weekly x□s four (4) and monthly x□s three (3) to ensure accuracy of orders and administration of medication. Issues identified will be investigated and immediately addressed. Results of audit findings will be reviewed for patterns and/or trends and a summary of the audits will be provided at the monthly QAPI meeting.	

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F 658	Continued From page 11 An interview was conducted with LPN #4, the nurse that signed off the removal of the lidocaine patch on 7/31/2023, on 8/1/2023 at 3:34 p.m. The above MAR was reviewed with LPN #4. When asked if she took the patch off last night LPN #4 stated she did. It was reviewed with LPN #4 that the resident had two patches prescribed. LPN #4 stated she took one off of her neck. The observation made on 8/1/2023 at 8:42 a.m. was reviewed with LPN #4. LPN #4 stated, "I guess I didn't take it off as I was so busy last night." The facility policy, "Medication Administration," documented in part, "3. Medications will be administered in accordance with the orders, including any required time frame." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 8/1/2023 at 4:01 p.m. (1) Lidocaine External Patch 4% is in a class of medications called local anesthetics. It works by stopping nerves from sending pain signals. Never wear them for more than 12 hours per day (12 hours on and 12 hours off). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a603026.html	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		8/25/23

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F 689	Continued From page 12 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, it was determined that the facility staff failed to implement fall interventions for one of 22 residents in the survey sample, Resident #242. The findings include: For Resident #242 (R242), the facility staff failed to place a fall mat on the floor to the left side of the bed while he was lying in bed. R242 was admitted to the facility with a diagnosis that included but was not limited to convulsion (1). R242's admission MDS (minimum data set) was not due at the time of the survey. On 08/01/23 at approximately 1:30 p.m., R242 was observed lying in bed asleep. Further observation failed to evidence a fall mat on the floor next to the bed. On 08/01/23 at approximately 3:20 p.m., R242 was observed lying in bed asleep. Further observation failed to evidence a fall mat on the floor next to the bed. The physician's order for R242 documented in part, "Fall mat in place to left side of bed when resident is in bed. Order Date: 07/31/2023."	F 689	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law. Correction of deficiency occurred 8/2/2023 with placement of the fall mat on resident #242□s left side of bed while resident is in bed as per physician order. All residents with orders for fall mats would be potentially impacted by this practice. On 8/3/2023 all orders for fall mats were reviewed, including resident #242 and no other residents were impacted. All care plans were correct. All staff were educated for following physician orders and implementation of fall mats for safety purposes. Unit manager or designee will audit physician orders for fall mats and implementation of fall mats are followed for current five (5) residents and any new residents requiring fall mats weekly x□s 4 then monthly x□s 3 to ensure compliance. Results of audit findings will be reviewed	

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F 689	Continued From page 13 The comprehensive care plan for R242 documented in part, "Focus. (R242) is at risk for falls characterized by history of falls, CVA (cerebral vascular accident) with left sided weakness related to: impaired balance, poor coordination. Date Initiated: 07/24/2023." Under "Interventions" it documented in part, "Fall mat in place to left side of bed when resident is in bed Date Initiated: 07/31/202." On 08/02/2023 at approximately 8:33 a.m., an interview was conducted with LPN (licensed practical nurse) #2. After informed of the above observations, review of the physician's orders and care plan LPN #2 stated that the fall matt should have been put in place. On 08/02/2023 at approximately 9:40 a.m., ASM (administrative staff member) #2, administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: Seizures | MedlinePlus.	F 689	for patterns and/or trends and a summary of the audits will be provided at the monthly QAPI meeting.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		8/25/23

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F 690	Continued From page 14 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide services to attempt to restore bladder and bowel continence for one of 22 residents in the survey sample, Resident #25.	F 690	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 690	Continued From page 15 The findings include: For Resident #25 (R25), the facility staff failed to provide evidence of attempting to restore her bladder and bowel function after admission to the facility. R25 was admitted to the facility on 8/24/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/26/23, R25 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as being frequently incontinent of both bowel and bladder. On the admission MDS (8/28/22) and the quarterly assessments (11/21/22 and 2/21/23) since her admission, she was also coded as being frequently incontinent of bowel and bladder. On all of these MDS assessments, R25 was coded as being independent for walking in her room. On 7/31/23 at 3:05 p.m., R25 was seated on the wheelchair in her room. When R25's incontinence was discussed and when asked if the facility staff had taken any steps to restore bladder or bowel continence since her admission, R25 stated: "No, they haven't." She stated she takes herself to the bathroom, but she sometimes needs help changing her brief [due to bowel or bladder incontinence episodes]. On 8/1/23 at 8:48 a.m., R25 was observed independently walking in her room. A review of R25's clinical record failed to reveal evidence of the facility staff's attempt to restore	F 690	All residents with the potential for bowel/bladder restoration could potentially be impacted by this practice. Resident #25 has been placed on an individualized resident centered toileting/bowel program as of 8/3/2023. All residents upon admission/re-admission and with each MDS assessment will be evaluated for a bowel and bladder restorative program. All clinical staff have been educated on identifying those residents who may benefit from a bowel and bladder restorative program. The Unit manager/Director of Nursing (DON) will perform an audit on residents who are identified as having fecal and urinary incontinence. Unit manager or designee will perform audits weekly x□s 4 then monthly x□s 3 to ensure compliance. Results of audit findings will be reviewed for patterns and/or trends and a summary of the audits will be provided at the monthly QAPI meeting.	

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F 690	Continued From page 16	F 690		

R25's continence of bowel or bladder, or rationale of why it wasn't attempted.

On 8/1/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

On 8/2/23 at 8:59 a.m., ASM #2 stated: "We don't really have anything to provide." She stated the facility staff had focused more on the resident's mobility than on bowel and bladder incontinence.

A review of the facility policy, "Fecal Incontinence," revealed, in part: "Residents with fecal incontinence will receive the appropriate treatment and services to restore as much normal bowel function as possible...Incontinence is not considered a normal part of the aging process...The resident will be evaluated for presence of fecal incontinence on admission/readmission and with each...MDS assessment. Consideration of factors impacting will be reviewed."

A review of the facility policy, "Assessment and Management of Urinary Function," revealed, in part: "Policy: To ensure each resident has an evaluation of urinary function and if urinary incontinence is identified, a determination is made of the type of urinary incontinence and appropriate treatment and services are implemented to restore as much bladder function as possible...When urinary function evaluation identifies urinary incontinence, a further evaluation will be completed...to determine appropriate treatment and/or interventions."

No further information was provided prior to exit.

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F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 22 residents in the survey sample, Resident #35. The findings include: The facility failed to provide a bagged lunch for Resident #35 to take with him to the dialysis appointment or offer additional food prior to going to dialysis. Resident #35 was admitted with diagnoses that include but are not limited to: ESRD (end stage renal disease. Resident #35's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/7/23, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of MDS Section O-Special Procedures: coded the resident as dialysis-yes. A review of the comprehensive care plan dated 12/12/19 and revised on 6/30/23, revealed, "FOCUS: Resident has end stage renal disease	F 698	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law. Corrected deficient practice for Resident #35 bagged lunch for off-site dialysis was corrected on 8/2/2023. Comprehensive care plan for dialysis care, specifically related to offering food prior to dialysis was updated on 8/2/2023. Upon review of current facility residents, it was determined that no other residents are currently receiving off-site dialysis. Policy impacting this practice was reviewed: Care of Resident with End Stage Renal Disease, was reviewed and updated to include, Residents with end-stage renal disease (ESRD) was edited to include the following statement: The facility will ensure that all resident□s nutritional needs are met while out of the facility receiving dialysis treatment by ensuring that if a meal is to be missed, the facility will provide an appropriate meal for	8/25/23

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F 698	Continued From page 18 and receives hemodialysis via left arm AV (arterio-venous) graft, 3 times a week on Monday, Wednesday and Friday. Resident is at increased nutritional risk related to requiring a therapeutic diet, food preferences for foods that contradict diet order, ESRD on hemodialysis, Heart Failure and Type 2 diabetes mellitus. Resident has nutritional risk related to related to heel pressure injury. INTERVENTIONS: Prepare and send meal with Richard as well as any other items he may need. Encourage to follow ordered diet to reduce risks of fluid overload/deficit and nutritional concerns. Revised 6/17/20: Dialysis no longer allows resident to take food into the center. Resident usually has a big breakfast each morning, monitor for the need to offer food prior to going out at 10 am and immediately upon returning from dialysis. Revised on 10/13/20: Currently foods are not allowed at dialysis due to COVID precautions. Provide snacks upon return as requested. Revised 6/30/23: Educate Resident / Representative regarding nutritional needs and requirements. Offer Juven supplement twice daily to promote wound healing." A review of the physician's order dated 1/20/22, revealed, "Dialysis every Mon-Wed-Fri at 11:00am pick up at 10:30am." A review of the nursing progress note dated 7/7/23 at 4:27 PM, revealed, "Last meal eaten: breakfast. Meal / snack was sent with the Resident." A review of the progress notes from 4/1/23-7/31/23 revealed no additional documentation of meal sent with resident.	F 698	the resident to take with them to dialysis. Dietary and clinical staff will be educated on the policy change. The Unit Manager or designee will audit for three (3) months to ensure that Resident #35 has a bagged lunch/meal on their regularly scheduled dialysis treatment days. Results of audit findings will be reviewed for patterns and/or trends and a summary of the audits will be provided at the monthly QAPI meeting.	

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F 698	Continued From page 19	F 698		

An interview was conducted on 7/31/23 at approximately 10:00 AM with Resident #35. Resident #35 was sitting in a wheelchair in his room, waiting for dialysis transport. When asked if he had a bagged lunch from the facility or if food was provided by the dialysis center, Resident #35 stated, "No, they do not give us food at the dialysis center. I have only been given lunch from this place once. Two sandwiches, since then no food. I do not get back till close to supper time and I have missed my lunch completely." Inside Resident #35's dialysis bag were one bag of hard candy and one bag of gummy candy. When asked about the candy, Resident #35 stated, "That is all I have to take to eat during dialysis."

An interview was conducted on 7/31/23 at 10:30 AM with OSM (other staff member) #3, the chef/manager and OSM #4, the dining services manager. When asked if brown bag lunch was provided to Resident #35 for his dialysis appointments, OSM #3 stated, "No, we do not provide a brown bag lunch." OSM #4 stated, "Our process is to provide him with food when he returns from dialysis." When asked about the timing of his return and supper time, OSM #4 stated, he gets back around 4:30-4:45 PM, it is close to when we are serving supper. When asked if he had missed a meal for his dialysis days, OSM #4 stated, yes.

An interview was conducted on 8/1/23 at 8:20 AM, with LPN (licensed practical nurse) #3. When asked if a lunch was provided to Resident #35 for his dialysis appointment, LPN #3 stated, "No, we are not sending a lunch with him."

On 8/1/23 at approximately 4:15 PM, ASM

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F 698	Continued From page 20 (administrative staff member) #1, the administrator, and ASM #2, the director of nursing was made aware of the findings. On 8/2/23 at 8:00 AM, ASM #2 stated, they have talked with the dialysis facility and they will be sending a brown bag lunch with him starting today. According to the facility's "Care of Resident with End Stage Renal Disease" policy, "Residents with end-stage renal disease (ESRD) will be cared for according to current recognized standards of care. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff may include: The nature and clinical management of ESRD, including infection prevention and nutritional needs." No further information was provided prior to exit.	F 698		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		8/25/23

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F 812	Continued From page 21 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in one of one kitchen areas. The findings include: The facility staff failed to date and/or dispose of opened food. On 7/31/23 at 9:15 AM, an observation was conducted in the main kitchen. In the freezer, one of two five-pound frozen hash browns packed in a plastic bag had been torn open. There was no label on the bag of the date it was opened or expiration date. An interview was conducted on 7/31/23 at 9:20 AM with OSM (other staff member) #1, the chef/dietary supervisor. When asked to review the opened hash brown bag, OSM #1 stated, "They must have just opened this with breakfast service. It should not be open like this. I will remove it." The ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing was made aware of the finding on 8/1/23 at 4:15 PM. The facility's "Infection Control Sanitation/Safety	F 812	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law. The item found to be open and undated was immediately removed and discarded on 7/31/2023. Any residents receiving food from dietary services have the potential to be affected by this practice. Policy impacting this practice was reviewed: Storage of frozen food - no changes were made. Cooks will be required to audit the frozen storage areas at the end of shift to identify any open undated items. The Chef Manager will in-service all dietary staff on the food storage policy(s). The walk-in freezers will be audited twice per week for 30 days and then weekly for 60 days by the Chef Manager or designee. Improperly opened or undated frozen foods will be immediately discarded and recorded, and variances will be	

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F 812	Continued From page 22 Guidelines" policy dated 8/2013, revealed the following, "Storage: The objective is to maintain high-quality food at approved temperatures and conditions to ensure retention of quality and safe conditions." No further information was provided prior to exit.	F 812	investigated and reported to the Director of Dietary Services. Results of audit findings will be reviewed for patterns and/or trends and a summary of the audits will be provided at the monthly QAPI meeting.	