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	495257	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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 9/11/2023 through 9/13/2023. 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 the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/11/23 through 09/13/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey (VA00057063-substantiated with deficiency; VA00058429-substantiated with deficiency; VA00056674-substantiated with deficiency). The Life Safety Code survey report will follow. The census in this 120 certified bed facility was 116 at the time of the survey. The survey sample consisted of 30 current resident reviews and seven closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		10/16/23

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

Electronically Signed | 10/05/2023

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, it was determined that the facility staff failed to promote dignity for one of 37 residents, Resident #24. The findings include: For Resident #24 (R24), the facility staff failed to	F 550	1. Resident #24 has confirmed her incontinence care needs are met by staff in a timely manner. 2. Incontinent residents will be audited to ensure that they are treated with respect and dignity including incontinence care needs are met in a timely manner by care	

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F 550	Continued From page 2 uphold the resident's dignity due to not providing timely incontinence care. R24 was admitted to the facility with diagnoses that included but were not limited to: muscle wasting and abnormalities of gait and mobility. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/20/2023, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating R24 was moderately impaired of cognition for making daily decisions. Under Section H "Bladder and Bowel" R24 was coded as being always incontinent of urine. On 09/11/23 at 12:35 p.m., an observation revealed that R24, who resided on the west unit at the facility, activated the call bell for incontinence care. On 09/11/23 at 12:45 p.m., an observation revealed CNA (certified nursing assistant) #2 entered R24's room, turned off the call and left the room with R24's lunch tray. On 09/11/2023 at 1:00 p.m., an observation revealed LPN (licensed practical nurse) #4 entered R24's room and provided incontinence care. On 09/12/23 at approximately 1:06 p.m., an interview was conducted with CNA (certified nursing assistant) #2. When asked about her entering R24's room at approximately 12:45 p.m., the day before, she stated that she picked up R24's meal tray and that R24 asked if she would clean her up. CNA	F 550	rounds. 3. Nursing staff and managers will be re-educated by October 9, 2023 to ensure residents are treated with respect and dignity including meeting incontinence care needs in a timely manner by the ADON/designee. 4. Department Managers/designee will conduct audits of incontinent residents 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure residents are treated with respect and dignity including meeting incontinence care needs in a timely manner. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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#2 stated that she told R24 that when she finished picking up the meal trays she would come back and provide incontinence care. When asked what time she finished picking up the meal trays, CNA #2 stated that it was after 1:00 p.m. but could not recall the exact time. When asked how long a resident should wait for incontinence care after informing a staff member, she stated that it should be done right away so the resident is not sitting in a soiled brief. When asked if R24's was on their assignment for Monday 9/11/2023, she stated yes. When informed of the above observations and that R24 waited approximately 25 minutes to receive incontinence care after activating her call bell and informing CNA #2, CNA #2 stated that she could have notified the nurse that R24 required incontinence care. When asked if it is dignified to have a resident wait in a soiled brief for approximately 25 minutes, she stated no.

On 09/12/23 at approximately 1:33 p.m., an interview was conducted with LPN (licensed practical nurse) #2, unit manager. When asked how long a resident should wait for incontinence care after informing a staff member, she stated that the resident should only have to wait within 15 to 20 minutes. When informed of the above observations LPN #2 stated that the CNA should have let the nurse know R24 required incontinence care. When asked if it is dignified to have a resident wait in a soiled brief for approximately 25 minutes, she stated no.

On 09/12/23 at approximately 1:53 p.m., an interview was conducted with LPN #4, MDS nurse. When asked if she entered R24's room on Monday, 09/11/2023 at approximately 1:00 p.m., she stated yes. When asked about

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F 550	Continued From page 4 providing incontinence care to R24, LPN #4 stated that she provided incontinence care, and that the resident was wet. LPN #4 further stated that she was not aware that R24 had been waiting for incontinence care because she had just walked onto the unit. When asked if it is dignified to have a resident wait in a soiled brief for approximately 25 minutes, she stated no. On 09/13/2023 at approximately 1:00 p.m., an interview was attempted with R24. When asked how she felt being left in a wet brief when she did not receive incontinence care when she asked for assistance, R24 stated that she did not want to speak to the surveyor. On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		10/16/23

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F 580	Continued From page 5 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined	F 580	1. Resident #225 (255) no longer resides in the facility. Resident #87 MD/NP has	

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F 580	Continued From page 6 that the facility staff failed to notify the physician medications not ordered and/or administered, for two of 37 residents in the survey sample, Resident #225 and Resident #87. The findings include: 1. For Resident #225 (R225), the facility staff failed to notify the physician when a medication, for the treatment of urinary retention, from a consulting physician was ordered. R225 was admitted with diagnoses that included but were not limited to benign prostatic hyperplasia (1). A urology office visit note for R225 documented in part, "11/25/2022 - Office visit: General. The patient was accompanied by his son ..." Under "Prescription(s) Today" it documented in part, "Dutasteride (2) 0.5 mg (milligram) capsule (dutasteride) Take 1 (one) capsule by mouth as directed at 9 am (9:00 a.m.) daily." Under "Plan" it documented in part, "We had a discussion regarding addition of 5-alpha reductase inhibitor (3) ..." The prescription slip from the urologist dated 11/25/2022 at 3:58 p.m. documented in part, "Dutasteride 0.5 mg capsule. Dispense 30 (thirty) capsules. Take (one) capsule by mouth as directed at 9 AM daily." The facility physician's order for R225 documented in part, "Dutasteride Capsule 0.5 MG. Give 1 capsule by mouth at bedtime for benign prostatic hyperplasia. Order Date: 11/28/2022."	F 580	been notified that levothyroxine sodium was not available on 9/10/23 and 9/11/23. 2. An audit will be conducted of residents who have had outside appointments in the last 30 days to ensure new orders for medications have been communicated to the MD/NP. An audit will also be conducted to ensure residents on levothyroxine sodium medications are available. Any concerns noted will be communicated to the MD/NP. 3. Licensed Nurses will be re-educated by October 9, 2023 regarding residents who have outside appointments returning with new orders for medications are communicated to the MD/NP. Education will also include notifying MD/NP of medications not available by the ADON/designee. 4. DON/designee will conduct audits of residents who have outside appointments to ensure new orders for medications have been communicated to the MD/NP and to ensure residents on levothyroxine sodium medications are available, if not MD/NP have been notified, in the clinical meeting 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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The eMAR (electronic medication administration record) for R225 dated November 2022 revealed the first dose of Dutasteride wasn't administered until 11/28/2022.

The nurse practitioner's (NP) note for R225 dated 11/28/2022 at 1:53 p.m., documented in part, "A/P (assessment/plan) ... Dutasteride added 11/28 ..."

Review of the facility's nursing progress notes dated 11/25/2022 through 11/27/2022 failed to evidence documentation of notification to the physician or NP of R225 consulting physician's order.

On 09/12/2023 at approximately 3:43 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked to describe the procedure when a resident brings in a prescription for a medication from a provider outside of the facility she stated that the nurse should put order in computer, talk to the physician or NP if they are in the building or call them to let them know the resident has a new prescription, put the script in the doctors book and call the pharmacy if the medication is not available in the facility. When asked if they recalled R225 and when R225's son brought him back to the facility from a urology appointment on 11/25/2022 she stated yes. LPN #8 stated that R225 and his son came back from an appointment between 7:00 p.m. and 8:00 p.m. with a prescription for urinary retention. LPN #8 further stated she did not call the physician.

On 09/13/2023 at approximately 11:00 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. When

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asked about R225 not receiving Dutasteride when it was ordered by the urologist, ASM #2 stated that the resident arrived around 8:00 p.m., the script was handed to the nurse and faxed it to the pharmacy but did not notify the on-call provider. She further stated that the NP was notified on the following Monday, 11/28/2022, and R225 received his first dose that day. When asked if there was a delay in R225 receiving his medication ASM #2 stated yes. When asked if the physician or NP was notified that R225 did not receive the medication of Dutasteride she stated no.

On 09/13/2023 at approximately 3:00 p.m., ASM (administrative staff member) #1, administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(2) Used alone or with another medication (tamsulosin [Flomax]) to treat benign prostatic hyperplasia (BPH; enlargement of the prostate gland). May reduce the chance of developing acute urinary retention. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603001.html.

(3) A class of medication used in the management and treatment of benign prostatic

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hyperplasia (BPH). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/
2. For Resident #87 (R87), the facility staff failed to notify the physician when the medication levothyroxine sodium (1) was not available for administration on 9/10/23 and 9/11/23.

A review of R87's clinical record revealed a physician's order dated 9/6/23 for levothyroxine sodium 75 mcg (micrograms)- one tablet by mouth in the morning for hypothyroidism. A review of R87's September 2023 MAR (medication administration record) revealed the same physician's order for levothyroxine sodium. On 9/10/23 and 9/11/23, the MAR documented the code, "5=Hold/See Nurse Notes." Nurses' notes dated 9/10/23 and 9/11/23 documented the medication was not available in the medication cart. Further review of nurses' notes and the September 2023 MAR failed to reveal documentation that levothyroxine sodium was administered to R87 on 9/10/23 and 9/11/23 and failed to reveal documentation that R87's physician was notified.

On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the physician should be notified when a medication is not available for administration because sometimes the physician can give another order.

On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

Reference:

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F 580	Continued From page 10 (1) "Levothyroxine is used to treat hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682461.html	F 580		
F 585 SS=D	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. §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	F 585		10/16/23

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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 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;

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F 585	Continued From page 12 (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 resident interview, staff interview, facility document review and clinical record review, the facility staff failed to promptly resolve a grievance for one of 37 residents in the survey sample, Resident #87. The findings include: For Resident #87 (R87), the facility staff failed to resolve the resident's grievance regarding her roommate. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/1/23, the resident scored 15	F 585	1. Resident #87 has been moved to a different room with satisfaction. 2. An audit of grievance logs for the last 30 days will be reviewed for timely resolution as able. 3. Social Service staff and Administrator will be re-educated by the RDO/designee by October 9, 2023 on ensuring the facility makes prompt efforts to resolve resident grievances in a timely manner. 4. Administrator/designee will conduct audits on ensuring the facility makes	

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F 585	Continued From page 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 9/11/23 at 2:48 p.m., an interview was conducted with the resident. R87 voiced concern that her roommate is often agitated, swears for hours and bangs on the snack table at different times throughout the day and night. R87 stated this has occurred since she moved into the room (on 8/1/23), her roommate keeps her up during the night, staff is aware, and no one has resolved this concern. At this time, R87's roommate was observed lying in bed and loudly speaking incoherent words. A review of R87's clinical record (progress notes for August 2023 and September 2023) and grievance logs for August 2023 and September 2023 failed to reveal documentation regarding the resident's concern. Nurse practitioner notes dated 8/4/23, 8/6/23 and 9/1/23 documented R87 complained of not sleeping well. On 9/12/23 at 12:50 p.m., an interview was conducted with LPN (licensed practical nurse) #2 (the unit manager). LPN #2 stated R87 has had complaints regarding her roommate and stated she's not getting any sleep. LPN #2 stated she spoke with R87's representative who agrees that the resident tends to say things that aren't true, and the nurses are reporting R87 is sleeping at night. LPN #2 stated she thought R87 wanted to be in a bed by the window, but the roommate didn't want to move, and no other room was available. LPN #2 stated she did not complete a grievance form regarding R87's concern but she spoke with the resident's representative on the previous day and the representative was happy	F 585	prompt efforts to resolve resident grievances with satisfaction in a timely manner, if possible, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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F 585	Continued From page 14 with everything. When asked what has been done to ensure R87's grievance was resolved and the resident was satisfied, LPN #2 stated she has verified with nurses that the resident is sleeping. On 9/12/23 at 5:11 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator and grievance officer). ASM #1 stated that anyone including residents, family members or staff can fill out a grievance form then the form is taken to the stand down or morning meetings and discussed. ASM #1 stated the grievance is then assigned to the appropriate discipline and those staff are responsible for investigating the grievance and developing a plan to try to resolve the grievance. ASM #1 stated that after this is done, staff is supposed to talk to the resident and determine if he or she is satisfied. On 9/12/23 at 5:15 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Program" documented, "All concerns/grievances are investigated, resolved, and documented..."	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff	F 641	1. Resident #103 MDS was modified to correctly code the discharge error to the	10/16/23

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F 641	Continued From page 15 failed to maintain an accurate MDS (minimum data set) assessment for one of 37 residents, Resident #103. The findings include: For Resident #103 (R103), the facility staff failed to code the discharge MDS assessment with an ARD (assessment reference date) of 7/3/2023 with the accurate discharge location. On the most recent MDS, the discharge assessment with an ARD of 7/3/2023, the resident was coded as having an unplanned discharge to the community. The progress notes for R103 documented in part, - "7/3/2023 19:16 (7:16 p.m.) Note Text: went to check on guest while awaiting return call from on call [medical provider], guest now c/o (complains of) of pain in lower abdominal area, no specific site; rp (responsible party) in room insisting guest to be sent out, will let np (nurse practitioner) know family choice." - "7/3/2023 19:52 (7:52 p.m.) Note Text: spoke with np told of change in condition and family request and agreed to transfer to hospital per rp request; rescue squad in transporting guest to (Name of hospital) accompanied by rp." On 9/13/2023 at 8:41 a.m., an interview was conducted with RN (registered nurse) #2, MDS nurse. RN #2 stated that they had daily clinical meetings to discuss skilled residents, discuss discharges and unplanned discharges and reviewed the 24 hour reports to find out any residents who were discharged or transferred to the hospital. She reviewed R103's discharge MDS with the ARD of 7/3/2023 and the progress	F 641	hospital instead of to the community. 2. An audit of discharged residents who have been discharged in the last 30 days will be conducted to ensure the discharge coding is correct. Any discharge residents noted to have discharge coding incorrect, will have the MDS modified and resubmitted as needed. 3. MDS staff will be re-educated by the Administrator by October 9, 2023 on coding discharge residents correctly. 4. Administrator/designee will conduct audits 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure discharged resident are coded correctly. Any MDS noted to be incorrect will have the MDS modified and resubmitted as needed A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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F 641	Continued From page 16 notes dated 7/3/2023 and stated that the MDS was not correct and should have been coded that they went to the hospital. She stated that the MDS needed to be corrected. She stated that they followed the RAI (resident assessment instrument) manual when completing the MDS assessments. According to the RAI Manual, Version 1.16, dated October 2018, section A2100: OBRA Discharge Status, documented in part, "Steps for Assessment: 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location ...Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home ... Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons ..." On 9/13/2023 at 9:30 a.m., ASM (administrative staff member) #1, the administrator was made aware of the concern. No further information was provided prior to exit.	F 641		
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	F 656		10/16/23

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F 656	Continued From page 17 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate 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-	F 656		

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F 656	Continued From page 18 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for five of 37 residents in the survey sample; Residents #100, #88, #91, #87, and #7. The findings include: The facility policy, "Care Planning" was reviewed. This policy documented, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs..." 1. For Resident #100, the facility staff failed to implement the comprehensive care plan for the use of an anticoagulant medication. A review of the clinical record revealed an order dated 8/25/23 for Eliquis (1) 5 mg (milligrams) twice daily for seven days; and an order dated 9/2/23 for Eliquis 5 mg once daily. A review of the comprehensive care plan revealed one dated 8/25/23 for "(Resident #100) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant." This care plan included the intervention, dated 8/25/23 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician" and one	F 656	1. Residents #100 no longer resides in the facility. Resident #87 orders have been updated to include non-pharmacological intervention to be offered/attempted prior to being administered PRN pain medication as well as her thyroid replacement therapy is being administered per MD orders. Resident #7 order for tramadol has been changed to scheduled. Resident #88 and Resident #91 no longer reside in the facility. 2. An audit will be conducted on residents who are administered PRN pain medications to ensure orders include non-pharmacological intervention are offered/attempted. An audit will also be conducted on residents on anti-coagulants to ensure orders include monitoring of anti-coagulant for side effects, to include bleeding and bruising. An audit will also be conducted to ensure residents on thyroid medications are available. 3. Licensed Nurses will be re-educated by October 9, 2023 regarding residents who are administered PRN pain medications have orders to include non-pharmacological intervention are offered/attempted and documentation of non-pharmacological intervention offered/ attempted, residents on anti-coagulants orders include monitoring of anti-coagulant for side effects, to include	

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F 656	Continued From page 19 dated 8/25/23 for "Observe and report to physician PRN (as-needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds." Further review of the clinical record failed to reveal any evidence of nurses monitoring for the use of an anticoagulant medication side effects related to risk of bleeding and bruising and other side effects. On 9/13/23 at 8:35 AM, an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that nurses should "watch for bruising, bleeding, things like that." She stated that monitoring should be throughout the day, not just a one-time check. She stated that it should be documented in the nurse's notes if there are or are not any signs and symptoms and to let the nurse practitioner know if there are any. She stated that if there isn't an order for monitoring, you can ask the doctor and put it in yourself. When asked if the care plan documented to monitor, how do you evidence that you followed it, she stated, "Your documentation." She stated that if there is no documentation evidence then the care plan is not being followed. On 9/13/23 at 8:46 AM, an interview was conducted with LPN #7. She stated that nurses should watch for bruising of any kind, coughing up blood, bleeding profusely from a wound or	F 656	bleeding and bruising and residents on thyroid medications are available by the ADON/designee. 4. DON/designee will conduct audits of the MAR of residents with PRN pain, anti-coagulants and thyroid medications in the daily clinical meeting, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure PRN pain medications have orders and documentation non-pharmacological intervention are offered/ attempted prior to administering PRN pain medications; orders and documentation of anti-coagulant being monitored for side effects, to include bleeding and bruising every evening shift and Thyroid medications are available. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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unusual places, change in condition. She stated that evidence of monitoring is done by charting on progress notes and a skin note. She stated that there should be a note every day even if nothing occurred so others will know what has been going on with the resident. She stated that if there is no evidence of monitoring, then the care plan is not being followed.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4 (Registered Nurse), the unit manager. She stated that each shift should be monitoring for side effects of anticoagulant medications. She stated that there should be documentation of the monitoring. She stated that she cannot say it is being monitored; if it is not documented it is not done. She stated that the care plan is not being followed if it is not documented.

On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.

References:
(1) Eliquis - "Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to

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prevent DVT and PE from happening again after the initial treatment is completed."
Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

2. For Resident #88, the facility staff failed to implement the comprehensive care plan for the use of an anticoagulant medication.

A review of the clinical record revealed an order dated 8/5/23 for Apixaban (1) (same as Eliquis) 5 mg (milligrams) twice daily for atrial fibrillation.

A review of the comprehensive care plan revealed one dated 3/20/23 for "(Resident #88) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant." This care plan included the intervention, dated 3/20/23 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician" and one dated 3/20/23 for "Observe and report to physician PRN (as-needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds."

Further review of the clinical record failed to reveal any evidence of nurses monitoring for the use of an anticoagulant medication side effects related to risk of bleeding and bruising and other

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side effects.

On 9/13/23 at 8:35 AM, an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that nurses should "watch for bruising, bleeding, things like that." She stated that monitoring should be throughout the day, not just a one-time check. She stated that it should be documented in the nurse's notes if there are or are not any signs and symptoms and to let the nurse practitioner know if there are any. She stated that if there isn't an order for monitoring, you can ask the doctor and put it in yourself. When asked if the care plan documented to monitor, how do you evidence that you followed it, she stated, "Your documentation." She stated that if there is no documentation evidence then the care plan is not being followed.

On 9/13/23 at 8:46 AM, an interview was conducted with LPN #7. She stated that nurses should watch for bruising of any kind, coughing up blood, bleeding profusely from a wound or unusual places, change in condition. She stated that evidence of monitoring is done by charting on progress notes and a skin note. She stated that there should be a note every day even if nothing occurred so others will know what has been going on with the resident. She stated that if there is no evidence of monitoring, then the care plan is not being followed.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4 (Registered Nurse), the unit manager. She stated that each shift should be monitoring for side effects of anticoagulant medications. She stated that there should be documentation of the monitoring. She stated that she cannot say it is being monitored; if it is not

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documented it is not done. She stated that the care plan is not being followed if it is not documented.

On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.

References:
(1) Eliquis - "Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed."
Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

3. For Resident #91, the facility staff failed to implement the comprehensive care plan for the use of an anticoagulant medication.

A review of the clinical record revealed a physician's order dated 9/11/23 for Coumadin (1) 5 mg (milligrams) daily, on Monday, Tuesday, Wednesday, Thursday, and Friday; and an order dated 9/11/23 for Coumadin 9.5 mg Saturday and

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Sunday, for atrial fibrillation.

A review of the comprehensive care plan revealed one dated 8/21/23 for "(Resident #91) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant." This care plan included the intervention, dated 8/21/23 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician" and one dated 8/21/23 for "Observe and report to physician PRN (as-needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds."

Further review of the clinical record failed to reveal any evidence of nurses monitoring for the use of an anticoagulant medication side effects related to risk of bleeding and bruising and other side effects.

On 9/13/23 at 8:35 AM, an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that nurses should "watch for bruising, bleeding, things like that." She stated that monitoring should be throughout the day, not just a one-time check. She stated that it should be documented in the nurse's notes if there are or are not any signs and symptoms and to let the nurse practitioner know if there are any. She stated that if there isn't an order for monitoring, you can ask the doctor and put it in yourself.

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When asked if the care plan documented to monitor, how do you evidence that you followed it, she stated, "Your documentation." She stated that if there is no documentation evidence then the care plan is not being followed.

On 9/13/23 at 8:46 AM, an interview was conducted with LPN #7. She stated that nurses should watch for bruising of any kind, coughing up blood, bleeding profusely from a wound or unusual places, change in condition. She stated that evidence of monitoring is done by charting on progress notes and a skin note. She stated that there should be a note every day even if nothing occurred so others will know what has been going on with the resident. She stated that if there is no evidence of monitoring, then the care plan is not being followed.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4 (Registered Nurse), the unit manager. She stated that each shift should be monitoring for side effects of anticoagulant medications. She stated that there should be documentation of the monitoring. She stated that she cannot say it is being monitored; if it is not documented it is not done. She stated that the care plan is not being followed if it is not documented.

On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.

References:
(1) Coumadin - "Warfarin is used to prevent blood clots from forming or growing larger in your blood

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and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung)."
Information obtained from https://medlineplus.gov/druginfo/meds/a682277.html
4.a. For Resident #87 (R87), the facility staff failed to implement the resident's comprehensive care plan for pain management.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/1/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

R87's comprehensive care plan dated 11/12/22 documented, "(R87) is at risk for pain r/t (related to) h/o (history of) multiple falls, chronic T12 (thoracic) compression fracture, fibromyalgia, degenerative arthritis, hx (history) ankle pain, back pain, right should contusion, bilateral knees...
Interventions: Offer Non-Pharmacological Interventions:
1)Massage
2)Meditation/Relaxation
3)Positioning
4)Ice/cold pack
5)Diversional Activity
6)Guided Imagery
7) Rest
8)Social Interaction..."

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A review of R87's clinical record revealed a physician's order dated 1/20/23 for ibuprofen 200 mg (milligrams)- one tablet by mouth every six hours as needed for pain. A review of R87's September 2023 MAR (medication administration record) revealed the resident was administered as needed ibuprofen on 9/1/23, 9/2/23, 9/3/23, 9/4/23, 9/6/23, 9/7/23 and 9/8/23. Further review of R87's clinical record (including the September 2023 MAR and September 2023 nurses' notes) failed to reveal non-pharmacological interventions were offered or attempted on all dates.

On 9/12/23 at 1:49 p.m., an interview was conducted with R87, who stated the nurses do not offer non-pharmacological interventions for pain management.

On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated care plans are individualized because everybody has different needs. LPN #3 stated the care plans tell you about what is needed to be done and if anyone has questions, they can look at the care plans. LPN #3 stated that prior to the administration of an as needed pain medication, nurses should offer interventions such as an ice packs, heating pads or repositioning, and document the offered interventions in the nurses' notes. LPN #3 stated non-pharmacological interventions are not always attempted each time an as needed pain medication is administered because sometimes non-pharmacological interventions cannot be attempted depending on the location or kind of pain, but nurses should try to offer non-pharmacological interventions if they can be attempted.

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On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

4.b. For Resident #87 (R87), the facility staff failed to implement the resident's comprehensive care plan for thyroid replacement therapy.

R87's comprehensive care plan dated 11/12/22 documented, "(R87) is at risk for complications of hypothyroidism such as: intolerance to cold, decreased appetite, weight gain, dry skin, mood changes, constipation, fatigue & bradycardia (low heart rate) ...Administer thyroid replacement therapy as ordered..."

A review of R87's clinical record revealed a physician's order dated 9/6/23 for levothyroxine sodium (1) 75 mcg (micrograms)- one tablet by mouth in the morning for hypothyroidism. A review of R87's September 2023 MAR (medication administration record) revealed the same physician's order for levothyroxine sodium. On 9/10/23 and 9/11/23, the MAR documented the code, "5=Hold./See Nurse Notes" Nurses' notes dated 9/10/23 and 9/11/23 documented the medication was not available in the medication cart. Further review of nurses' notes and the September 2023 MAR failed to reveal documentation that levothyroxine sodium was administered to R87 on 9/10/23 and 9/11/23.

A review of the facility backup medication supply list revealed levothyroxine sodium 75 mcg tablets were available in the supply.

On 9/12/23 at 3:20 p.m., an interview was

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conducted with LPN (licensed practical nurse) #3. LPN #3 stated care plans are individualized because everybody has different needs. LPN #3 stated the care plans tell you about what is needed to be done and if anyone has questions, they can look at the care plans. LPN #3 stated nurses should re-order medications from the pharmacy when there are five or six pills left. LPN #3 stated if a medication is not available for administration, the medication should be pulled from the backup medication supply, and if the medication is not available in the supply, then the nurses should call the pharmacy and ask for the medication to be sent STAT (immediately).

On 9/13/23 at 3:07 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

Reference:
(1) "Levothyroxine is used to treat hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682461.html.
5. For Resident #7 (R7) the facility staff failed to implement the comprehensive care plan for the use of non-pharmacological interventions prior to the administration of a prn (as needed) pain medication, Tramadol (1).

R7 was admitted with diagnosis that included but not limited to osteoarthritis (2) of the knee.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/20/2023, the resident

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scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R7 was cognitively intact for making daily decisions. Section J "Pain Management" coded R7 as having frequent pain at a pain level of six out of ten, with ten being the worse pain.

The physician order for R7 documented in part, "Tramadol HCl (hydrochloride) Tablet 50 MG (milligrams). Give 1 (one) tablet by mouth every 8 (eight) hours as needed for Pain level 6-10. Order Date: 10/25/2022."

The eMAR (electronic medication administration record) for R7 dated august 2023 documented the physician's orders as stated above. The eMAR revealed that R7 received 67 doses of Tramadol 50mgs between 08/01/2023 and 08/31/2023 with no evidence of non-pharmacological interventions being attempted and documentation of the location of R7's pain and the type of pain.

The eMAR (electronic medication administration record) for R7 dated September 2023 documented the physician's orders as stated above. The eMAR revealed that R7 received 20 doses of Tramadol 50mgs between 09/01/2023 and 09/11/2023 with no evidence of non-pharmacological interventions being attempted prior to the administration of Tramadol for R7.

The nursing progress notes for R7 dated 08/01/2023 through 09/11/2023 failed to evidence documentation of non-pharmacological interventions being attempted prior to the administration of Tramadol for R7.

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R7's comprehensive care plan dated 02/22/2022 documented in part, "Need. (R7) actual pain episodes r/t (related to) severe L (left) knee OA (osteoarthritis) with debility, Chronic pain d/t (due to) RA (rheumatoid arthritis), lumbar radiculopathy, h/o (history of) migraines, DM (diabetes mellitus) with neuropathy. Date Initiated: 02/22/2022." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions. 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional activity. 6) Guided Imagery. 7) Rest. 8) Social interaction. 9)Other. Date Initiated: 02/22/2022."

On 09/12/23 at approximately 9:21 a.m., an interview was conducted with R7. When asked if the facility staff attempt non-pharmacological intervention prior to administrating Tramadol, R7 stated no.

On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. She stated in regard to non-pharmacological interventions, LPN #3 stated nurses should offer interventions such as an ice packs, heating pads or repositioning, and document the offered interventions in the nurses' notes. LPN #3 stated non-pharmacological interventions are not always attempted each time an as needed pain medication is administered because sometimes non-pharmacological interventions cannot be attempted depending on the location or kind of pain, but nurses should try to offer non-pharmacological interventions if they can be attempted.

On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator,

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F 656	Continued From page 32 ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Tramadol is used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. (2) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for three of 37 residents in the survey sample, Residents #87, #55 and #225. The findings include: 1. For Resident #87 (R87), the facility staff failed	F 658	1. Resident #87 MD/NP has been notified that levothyroxine sodium was not available on 9/10/23 and 9/11/23. Resident #55 and Resident #225 (255) no longer reside in the facility. 2. An audit will be conducted of residents who have orders for nothing by mouth to ensure medications are not ordered to be	10/16/23

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F 658	Continued From page 33 to administer the medication levothyroxine sodium (1) 75 mcg (micrograms) per physician's order on 9/10/23 and 9/11/23. A review of R87's clinical record revealed a physician's order dated 9/6/23 for levothyroxine sodium 75 mcg- one tablet by mouth in the morning for hypothyroidism. A review of R87's September 2023 MAR (medication administration record) revealed the same physician's order for levothyroxine sodium. On 9/10/23 and 9/11/23, the MAR documented the code, "5=Hold/See Nurse Notes." Nurses' notes dated 9/10/23 and 9/11/23 documented the medication was not available in the medication cart. Further review of nurses' notes and the September 2023 MAR failed to reveal documentation that levothyroxine sodium was administered to R87 on 9/10/23 and 9/11/23. A review of the facility backup medication supply list revealed levothyroxine sodium 75 mcg tablets were available in the supply. On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated nurses should re-order medications from the pharmacy when there are five or six pills left. LPN #3 stated if a medication is not available for administration, the medication should be pulled from the backup medication supply, and if the medication is not available in the supply, then the nurses should call the pharmacy and ask for the medication to be sent STAT (immediately). On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 658	given by mouth, levothyroxine sodium medications are available and residents who have had outside appointments in the last 30 days to ensure new orders for medications have been communicated to the MD/NP. 3. Licensed Nurses will be re-educated by October 9, 2023 regarding residents who have orders for nothing by mouth to ensure medications are not ordered to be given by mouth, levothyroxine sodium medications are available and residents who have had outside appointments to ensure new orders for medications have been communicated to the MD/NP by the ADON/designee. 4. DON/designee will conduct audits of residents who have orders for nothing by mouth to ensure medications are not ordered to be given by mouth, thyroid medications are available and residents who have had outside appointments to ensure new orders for medications have been communicated to the MD/NP in the daily clinical meeting, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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above concern.

The facility policy titled, "Medication Administration" documented, "Medications are administered in accordance with written orders of the attending physician."

Reference:
(1) "Levothyroxine is used to treat hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682461.html.

2. For Resident #55 (R55), the facility staff failed to accurately transcribe a physician's order to administer the resident's potassium via PEG (percutaneous endoscopic gastrostomy) tube instead of via mouth.

A review of R55's clinical record revealed a physician's order dated 8/17/23 for, "Nothing by Mouth diet, Nothing by Mouth texture, Nothing by Mouth consistency." Further review of R55's clinical record revealed a physician's order dated 8/18/23 for potassium chloride liquid 20 milliequivalents/15 milliliters- 20 milliequivalents by mouth three times a day.

On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated if a resident with a peg tube has a physician's order for nothing by mouth, then medications should be administered via peg, and the order should document that. LPN #3 stated that when the nurses put orders into the computer system, they get used to entering the route as "by mouth" and someone may have unintentionally

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entered the wrong route for R55's potassium.

Interviews were conducted with nurses who cared for R55. The nurses stated they administer the resident's medications via peg.

On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "The licensed nurse receiving the order must verify to ensure the order is complete and it includes: Accurate route..."

3. For Resident #225 (R225), the facility staff failed to obtain a physician's order as prescribed by the consulting physician for the medication, Dutasteride (1), used for urinary retention.

R225 was admitted with diagnoses that included but were not limited to benign prostatic hyperplasia (2).

A urology office visit note for R225 documented in part, "11/25/2022 - Office visit: General. The patient was accompanied by his son ..." Under "Prescription(s) Today" it documented in part, "Dutasteride (2) 0.5 mg (milligram) capsule (dutasteride) Tale 1 (one) capsule by mouth as directed at 9 am (9:00 a.m.) daily."

The prescription slip from the urologist for R225 dated 11/25/2022 at 3:58 p.m. documented in part, "Dutasteride 0.5 mg capsule. Dispense 30 (thirty) capsules. Take (one) capsule by mouth as directed at 9 AM daily."

The facility physician's order for R225

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documented in part, "Dutasteride Capsule 0.5 MG. Give 1 capsule by mouth at bedtime for benign prostatic hyperplasia. Order Date: 11/28/2022."

The eMAR (electronic medication administration record) for R225 dated November 2022 documented the physician's order as stated above, however the first dose of dutasteride wasn't administered until 11/28/2022.

The nurse practitioner's (NP) note for R225 dated 11/28/2022 at 1:53 p.m., documented in part, "A/P (assessment/plan) ... Dutasteride added 11/28 ..."

On 09/12/2023 at approximately 3:43 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked to describe the procedure when a resident brings in a prescription for a medication from a provider outside of the facility she stated that the nurse should put order in computer, talk to the physician or NP if they are in the building or call them to let them know the resident has a new prescription, put the script in the doctors book and call the pharmacy if the medication is not available in the facility. When asked if they recalled R225 and when R225's son brought him back to the facility from a urology appointment on 11/25/2022 she stated yes. LPN #8 stated that R225 and his son came back from an appointment between 7:00 p.m. and 8:00 p.m. with a prescription for urinary retention. LPN #8 further stated she did not call the physician.

On 09/13/2023 at approximately 9:52 a.m., an interview was conducted with ASM (administrative staff member) #4, nurse practitioner. When

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asked to describe the procedure she follows when a resident receives a script for a prescription from a provider outside of the facility, she stated that the staff gives the scrip to her the day the resident receives it or the next morning. She further stated that if she were not in the facility the nurse would call the on-call provider. When asked if she recalled R225 and the order for Dutasteride she stated that she did and further stated that that staff could not locate the order and she had them call the pharmacy and verify the order on Monday (11/28/2023).

On 09/13/2023 at approximately 11:00 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. When asked about R225 not receiving Dutasteride when it was ordered by the urologist ASM #2 stated that the resident arrived around 8:00 p.m., the script was handed to the nurse and faxed it to the pharmacy but did not notify the on-call provider. She further stated that the NP was notified on the following Monday, 11/28/2022, and R225 received his first dose that day. When asked if there was a delay in R225 receiving his medication ASM #2 stated yes.

The facility's grievance form for R225 dated 11/29/2022 documented in part, "What is your concern about? Had urology appt (appointment) Friday and brought paperwork and prescription back. Handed to a nurse. Visited Monday morning and medication was not ordered. Concerned this is a setback. When did the problem occur? Friday 11/25/22. Facility Response: NP reached out to urologist and got new script and ordered medication. Action To Be Taken: Writer spoke with nurse. Nurse stated that she received the paperwork, faxed the

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F 658	Continued From page 38 prescription to the pharmacy and placed in the scan pile. She stated she did not put the order in PCC (point click care - electronic health record. Writer informed nurse that paperwork is to be placed in the MD (medical doctor) book and order put in PCC." On 09/13/2023 at approximately 3:00 p.m., ASM (administrative staff member) #1, administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) Used alone or with another medication (tamsulosin [Flomax]) to treat benign prostatic hyperplasia (BPH; enlargement of the prostate gland). May reduce the chance of developing acute urinary retention. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603001.html. (2) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (3) A class of medication used in the management and treatment of benign prostatic hyperplasia (BPH). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		10/16/23

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F 676	Continued From page 39 §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 676	1. Resident #24 has confirmed her ADL	

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F 676	Continued From page 40 interview, clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) for one of 37 residents, Resident #24. The findings include: For Resident #24 (R24), the facility staff failed to provide timely incontinence care. R24 was admitted to the facility with diagnoses that included but were not limited to: muscle wasting and abnormalities of gait and mobility. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/20/2023, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating R24 was moderately impaired of cognition for making daily decisions. Under Section H "Bladder and Bowel" R24 was coded as being always incontinent of urine. On 09/11/23 at 12:35 p.m., an observation revealed that R24 activated the call bell for incontinence care. On 09/11/23 at 12:45 p.m., an observation revealed CNA (certified nursing assistant) #2 entered R24's room, turned off the call and left the room with R24's lunch tray. On 09/11/2023 at 1:00 p.m., an observation revealed LPN (licensed practical nurse) #4 entered R24's room and provided incontinence care. On 09/12/23 at approximately 1:06 p.m., an interview was conducted with CNA (certified	F 676	needs are met to include incontinence care met by staff. 2. Incontinent residents will be audited to ensure that their ADL needs are met by staff in a timely manner, including incontinence care by care rounds. 3. Nursing staff will be re-educated by October 9, 2023 to ensure residents ADL needs are met by staff in a timely manner, including incontinence care by the ADON/designee. 4. Department Managers/designee will conduct audits by way of care rounds of incontinent residents 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure residents ADL are met by staff in a timely manner, including incontinence care. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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nursing assistant) #2. When asked about her entering R24's room at approximately 12:45 p.m., the day before, she stated that she picked up R24's meal tray and that R24 asked if she would clean her up. CNA #2 stated that she told R24 that when she finished picking up the meal trays she would come back and provide incontinence care. When asked what time she finished picking up the meal trays, CNA #2 stated that it was after 1:00 p.m. but could not recall the exact time. When asked how long a resident should wait for incontinence care after informing a staff member, she stated that it should be done right away so the resident is not sitting in a soiled brief. When asked if R24's was on their assignment for Monday 0-9/11/2023, she stated yes. When informed of the above observations and that R24 waited approximately 25 minutes to receive incontinence care after activating her call bell and informing CNA #2, CNA #2 stated that she could have notified the nurse that R24 required incontinence care.

On 09/12/23 at approximately 1:33 p.m., an interview was conducted with LPN (licensed practical nurse) #2, unit manager. When asked how long a resident should wait for incontinence care after informing a staff member, she stated that the resident should only have to wait within 15 to 20 minutes. When informed of the above observations LPN #2 stated that the CNA should have let the nurse know R24 required incontinence care.

On 09/12/23 at approximately 1:53 p.m., an interview was conducted with LPN #4, MDS nurse. When asked if she entered R24's room on Monday, 09/11/2023 at approximately 1:00 p.m., she stated yes. When asked about

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F 676	Continued From page 42 providing incontinence care to R24, LPN #4 stated that she provided incontinence care, and that the resident was wet. LPN #4 further stated that she was not aware that R24 had been waiting for incontinence care because she had just walked onto the unit. The facility's policy "Routine Resident Care" it documented in part, "Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene." Under "Guidelines" to documented in part, "8. Incontinence care is provided timely according to each resident's needs." On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		10/16/23

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F 686	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services for the treatment of pressure injuries for one of 37 residents in the survey sample; Resident #205. The findings include: The facility policy, "Skin Management" was reviewed. This policy documented, "....Upon admission/re-admission all guests/residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic medical record....4. Guests/residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing, A physician's order for treatment, and Wound location, measurements and characteristics documented...." The facility staff failed to document descriptions, measurements, and staging of two wounds after the initial admission documentation, until the wound care physician saw the resident approximately seven days after admission; and, failed to evidence that treatment was initiated until two days after admission. Resident #205 was admitted to the facility on 8/17/22 and discharged on 9/22/22. A review of the admission MDS (Minimum Data Set) dated 8/24/22, revealed the resident was admitted with two stage-two pressure wounds. Review of the clinical record failed to reveal any	F 686	1. Resident #205 no longer resides in the facility. 2. Residents with pressure ulcers will be audited to ensure documentation of wounds is complete including descriptions, measurements, staging and treatment orders are initiated. 3. Licensed nurses will be re-educated by October 9, 2023 on ensuring pressure ulcer documentation is complete including descriptions, measurements, staging and treatment orders are initiated by the ADON/designee. 4. DON/designee will conduct audits of pressure ulcer documentation 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure documentation is complete including descriptions, measurements staging and treatment orders are initiated. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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evidence of where the MDS staging came from as it was not documented anywhere. Also, the clinical record failed to reveal evidence that treatment was initiated upon admission and for the first two days of admission.

A review of the clinical record revealed the following orders and administration of those orders, in chronological order of the order date:

An order 8/18/22 for wound consult as-needed. The wound physician notes were reviewed. The wound physician saw the resident on 8/22/22, 8/31/22, 9/14/22, and 9/21/22.

An order 8/18/22 for right buttock - cleanse with normal saline, pat dry, cover with medihoney foam every day shift. A review of the TAR (Treatment Administration Record) for August 2022 revealed this order was discontinued on 8/20/22 and was administered as ordered.

An order 8/20/22 for bilateral buttocks - cleanse with normal saline, pat dry, cover with medihoney foam every day shift for wound. A review of the TAR for August 2022 revealed this order was discontinued on 8/24/22 and was administered as ordered.

An order 8/24/22 left buttock - cleanse with normal saline, pat dry, cover with medihoney and foam every day shift. A review of the TAR for August and September 2022 revealed this order was discontinued on 9/8/22 and was administered as ordered.

An order 8/24/22 right buttock - cleanse with normal saline, pat dry, cover with medihoney and foam every day shift for wound. A review of the

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TAR for August and September 2022 revealed this order was discontinued on 9/8/22 and was administered as ordered.

An order 9/8/22 barrier cream to bilateral buttocks every shift. A review of the TAR revealed this order was discontinued upon discharge and was completed as ordered except one time out of 42 opportunities it was not documented. There was no evidence whether it was done and not documented or was not done. There was no evidence that this resulted in any negative impact on the resident.

Further review of the clinical record revealed the following notes and assessments, in chronological order:

The admission nurse's note dated 8/17/22 documented the resident arrived at 8:15 PM and that there was a "...right buttock open red area 1 cm....open area on left buttock approximately 1 cm wide..."

The nurse practitioner note dated 8/18/22, the initial assessment of this resident, did not address the wounds.

A skin assessment dated 8/19/22 at 4:02 PM documented "....Number of new skin conditions: 0. Comments: open area to buttocks...."

The nurse practitioner note dated 8/20/22 at 4:01 PM documented, "...skin:...Bilateral buttock wounds....wound care order updated...."

The nurse practitioner note dated 8/22/22 at 10:14 AM documented, "...buttocks wounds assessed, dressing lifted..."

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The nurse practitioner note dated 8/24/22 at 12:23 PM documented, "...seen in bed, wounds assessed with wound MD, b/l (bilateral) buttocks wounds healing well..."

The wound physician note dated 8/24/22 documented, "...Stage 3 pressure wound right buttock...Wound Size (L x W x D) 2.9 x 1.6 x 0.1.....Stage 3 pressure wound of the left buttock...Wound Size (L x W x D) 3 x 2.1 x 0.1..."

The wound physician note on 8/24/22 was the first with complete measurements, staging, and description of the wounds, which was approximately seven days after admission. There was no evidence of measurements other than the one centimeter documented on admission which was not a complete measurement, any description other than "red" and "open area" on admission, and any staging of these wounds prior to this note. In addition, there was no evidence that any wound treatment was initiated upon admission when the wound was initially identified, until approximately 16 hours after admission, and the first application of this treatment was not documented until 8/19/22, per the August 2022 TAR.

The wound physician note dated 8/31/22 documented, "...Stage 3 pressure wound right buttock...Wound Size (L x W x D) 1.4 x 0.9 x 0.1.....Stage 3 pressure wound of the left buttock...Wound Size (L x W x D) 2.6 x 0.5 x not measureable..."

The next wound physician note was dated 9/14/22. This note documented that as of 9/14/22, both wounds were resolved. There were

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no other wounds on this review note.

On 9/13/23 at 8:52 AM, an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that when a resident is admitted with wounds, the wounds should be assessed, cleaned and dressed. She stated that staff should obtain wound orders for it, implement the orders, and the next morning the unit manager and the doctor go in and do their assessment. She stated that wounds should be accurately documented as to what the resident has and where they are located, a detailed description of the wound and treatment should be initiated right away. She stated that when staff assess a wound, they are going to have to dress it, and that treatment orders should have been obtained immediately.

On 9/13/23 at 9:52 AM, an interview was conducted with ASM #4 (Administrative Staff Member), the nurse practitioner. She stated that the wounds were healed. She did not have any concerns regarding the wound treatment.

On 9/13/23 at 10:10 AM, an interview was conducted with ASM #5, the wound care physician. He did not recall the resident and was unable to speak to the pressure wounds prior to his initial evaluation of the wound, approximately one week after admission.

On 9/13/23 at 10:46 AM, an interview was conducted with RN #2 (Registered Nurse), the MDS nurse. She stated that when the resident was admitted, he came in with two open areas. She stated that she made her own observations of the resident's wounds in order to stage them for the MDS because there was no staging

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documented in the clinical record. She stated that she does not know what day she made the observation but that typically, she does her observations and interviews on or close to the ARD (Assessment Reference Date) of the MDS. The ARD for the admission MDS was 8/24/22, the same day as the wound care physician's first visit. She stated that her observations and interviews would not have been done the day of or in the day or two following admission; it would have been closer to the ARD date.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4, the unit manager. She stated that the initial skin check and then two more in the next 24 hours should be done-at admission and each following shifts for two more times. She stated that documentation should be as descriptive as possible. She stated that the nurse practitioner or physician should then go in and see the wounds to verify what stage they are. She stated that RN's are able to stage wounds but not everyone is comfortable. She stated that she tries to see all wounds in the first 24 hours. She stated that she would do a description and her own clinical opinion on what the stage is. She stated that there should have been treatment initiated and a note that wound care was provided and that orders should have been obtained on admission to get something started. She stated that there should be documentation on wound sizing, description, and staging. She stated that there should have been better documentation of the wound and wound care initiated and a note that wound care was provided even if there wasn't an order in place yet.

On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the

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F 686	Continued From page 49 Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.	F 686		
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, staff interview, and clinical record review, it was determined that facility staff failed to provide respiratory care and services in a sanitary manner for one of 37 residents in the survey sample, Residents #21. The findings include: For Resident #21 (R21), the facility staff failed to store a CPAP (continuous positive airway pressure) (1) mask in a sanitary manner. R21 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive sleep apnea (2). On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/14/2021, R21 scored 15 out of 15 on the BIMS (brief interview for mental status), the resident	F 695	1. Resident #21 C-pap mask was immediately bagged in a sanitary manner. 2. Residents with C-pap machines will be audited to ensure masks are bagged in a sanitary manner. 3. Nursing staff and managers will be re-educated by October 9, 2023 on ensuring C-pap masks are bagged in a sanitary manner by the ADON/designee. 4. Managers/designee will conduct audits of residents who have C-pap machines 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure masks are bagged in a sanitary manner. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	10/16/23

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F 695	Continued From page 50	F 695		

was cognitively intact for making daily decisions. Section O "Special Treatments, Procedures and Programs" coded R21 for "CPAP" while a resident.

On 09/11/23 at approximately 12:32 p.m., an observation of R21's room revealed a CPAP mask laying on the over-the-bed table uncovered.

On 09/11/23 at approximately 4:30 p.m., an observation of R21's room revealed a CPAP mask laying on the over-the-bed table uncovered.

On 09/12/23 at approximately 9:00 a.m., an observation of R21's room revealed a CPAP mask laying on the over-the-bed table uncovered.

The physician's order for R21 documented in part, "CPAP to be on when laying down as tolerated set at prescribed settings. every shift for hypoxia. Start Date: 06/15/2021."

On 09/12/23 at approximately 9:01 a.m., an interview was conducted with R#38. When asked about the storage of the CPAP mask she stated that the facility have not provided a bag to store it in and that she is unable to reach the mask and relies of the staff to place the mask in a bag.

On 09/13/2023 at approximately 11:00 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. After informed of the above observations she was asked how a resident's CPAP mask should be stored when it is not being used. ASM #2 stated that it should be covered to keep it clean.

On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator,

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F 695	Continued From page 51 ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. (2) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: 2. For R7 the facility staff failed to identify the location of the pain, the type of pain and attempts of non-pharmacological interventions prior to the	F 697	1 Resident #87 and Resident #7 non-pharmacological intervention are being offered/attempted prior to being	10/16/23

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F 697	Continued From page 52 administration of a prn (as needed) pain medication, Tramadol (1). R7 was admitted with diagnosis that included but not limited to osteoarthritis (2) of the knee. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/20/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R7 was cognitively intact for making daily decisions. Section J "Pain Management" coded R7 as having frequent pain at a pain level of six out of ten, with ten being the worse pain. R7's comprehensive care plan dated 02/22/2022 documented in part, "Need. (R7) actual pain episodes r/t (related to) severe L (left) knee OA (osteoarthritis) with debility, Chronic pain d/t (due to) RA (rheumatoid arthritis), lumbar radiculopathy, h/o (history of) migraines, DM (diabetes mellitus) with neuropathy. Date Initiated: 02/22/2022." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions. 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional activity. 6) Guided Imagery. 7) Rest. 8) Social interaction. 9)Other. Date Initiated: 02/22/2022." The physician order for R7 documented in part, "Tramadol HCl (hydrochloride) Tablet 50 MG (milligrams). Give 1 (one) tablet by mouth every 8 (eight) hours as needed for Pain level 6-10. Order Date: 10/25/2022." The eMAR (electronic medication administration record) for R7 dated august 2023 documented	F 697	administered PRN pain medication. 2 An audit will be conducted on residents who are administered PRN pain medications to ensure orders include non-pharmacological intervention are offered/attempted. 3 Licensed Nurses will be re-educated by October 9, 2023 regarding offering/attempting non-pharmacological intervention prior to administering PRN pain medications by the ADON/designee. 4 DON/designee will conduct audits of the MAR of residents with PRN pain medications in the daily clinical meeting, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure non-pharmacological intervention are offered/attempted prior to administering PRN pain medications and documented. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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the physician's orders as stated above. The eMAR revealed that R7 received 67 doses of Tramadol 50 mgs between 08/01/2023 and 08/31/2023, with no evidence of non-pharmacological interventions attempted and no documentation of the location and type of R7's pain.

The eMAR (electronic medication administration record) for R7 dated September 2023 documented the physician's orders as stated above. The eMAR revealed that R7 received 20 doses of Tramadol 50 mgs between 09/01/2023 and 09/11/2023 with no evidence of non-pharmacological interventions attempted and no documentation of the location and type of R7's pain.

The nursing progress notes for R7 dated 08/01/2023 through 09/11/2023 failed to evidence documentation of non-pharmacological interventions prior to the administration of Tramadol and the location and type of R7's pain.

On 09/12/23 at approximately 9:21 a.m., an interview was conducted with R7. When asked if the facility staff attempt non-pharmacological intervention, ask for the location of pain or type of pain prior to administrating Tramadol, R7 stated no.

On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that prior to administering an as needed pain medication, the nurses should ask the resident where the pain is, ask the resident if the pain is throbbing or sharp, ask the resident to rate the pain, ask the resident if the pain is new, observe for non-verbal indicators of pain, and

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document the assessment. LPN #3 stated a complete pain assessment is important because the pain may be something that requires more than just a pain pill. LPN #3 stated the resident may need to be seen by a doctor or transferred out of the facility. In regard to non-pharmacological interventions, LPN #3 stated nurses should offer interventions such as an ice packs, heating pads or repositioning, and document the offered interventions in the nurses' notes. LPN #3 stated non-pharmacological interventions are not always attempted each time an as needed pain medication is administered because sometimes non-pharmacological interventions cannot be attempted depending on the location or kind of pain, but nurses should try to offer non-pharmacological interventions if they can be attempted.

On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Tramadol is used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

(2) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips, or spine. This information was obtained from the website:

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https://medlineplus.gov/osteoarthritis.html.
Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to implement a complete pain management program for two of 37 residents in the survey sample, Residents #87 and #7.

The findings include:

1. For Resident #87 (R87), the facility staff failed to initiate a complete pain assessment and failed to attempt non-pharmacological interventions when the as needed pain medication ibuprofen was administered on multiple dates in September 2023.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/1/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

A review of R87's clinical record revealed a physician's order dated 1/20/23 for ibuprofen 200 mg (milligrams)- one tablet by mouth every six hours as needed for pain. A review of R87's September 2023 MAR (medication administration record) revealed the resident was administered as needed ibuprofen on 9/1/23, 9/2/23, 9/3/23, 9/4/23, 9/6/23, 9/7/23 and 9/8/23. Further review of R87's clinical record (including the September 2023 MAR and September 2023 nurses' notes) failed to reveal a completer pain assessment (including location, quality and duration) was completed on all dates and failed to reveal non-pharmacological interventions were offered or attempted on all dates.

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On 9/12/23 at 1:49 p.m., an interview was conducted with R87. R87 stated that sometimes the nurses ask the resident's pain level prior to administering ibuprofen but the nurses do not ask the location and description of the pain. R87 further stated the nurses do not offer non-pharmacological interventions.

On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that prior to administering an as needed pain medication, the nurses should ask the resident where the pain is, ask the resident if the pain is throbbing or sharp, ask the resident to rate the pain, ask the resident if the pain is new, observe for non-verbal indicators of pain, and document the assessment. LPN #3 stated a complete pain assessment is important because the pain may be something that requires more than just a pain pill. LPN #3 stated the resident may need to be seen by a doctor or transferred out of the facility. In regard to non-pharmacological interventions, LPN #3 stated nurses should offer interventions such as an ice packs, heating pads or repositioning, and document the offered interventions in the nurses' notes. LPN #3 stated non-pharmacological interventions are not always attempted each time an as needed pain medication is administered because sometimes non-pharmacological interventions cannot be attempted depending on the location or kind of pain, but nurses should try to offer non-pharmacological interventions if they can be attempted.

On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the

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F 697	Continued From page 57 above concern. The facility policy titled, "Pain Management" documented, "1. Upon admission/re-admission, quarterly, with a significant change in condition and PRN (as needed) residents will be evaluated for pain by the licensed nurse. 2. Additionally, residents will be monitored for the presence of pain and evaluated when there is a change in condition and whenever new pain or an exacerbation of pain is suspected. 3.Observe resident for indicators of pain (refer to table 3), indicators include: -Moaning, crying, and other vocalizations -Wincing or frowning and other facial expressions -Body posture such as guarding or protecting an area of the body, or lying very still -Decrease in usual activities... 5. Ask the resident and observe to determine the frequency of pain: -No pain -Pain less than daily -Pain daily... 7. Ask the resident and observe to determine the location of pain... 9. Each resident identified with pain will have a Pain Management Care Plan. The care plan will have: Individualized interventions related to that resident's individual control of pain management should include both pharmacological, non-pharmacological, and include Complementary and Alternative Medicine (CAM) pain management interventions..."	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		10/16/23

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F 698	Continued From page 58 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, clinical record review and facility document review, it was determined that the facility staff failed to evidence communication with the dialysis center for each dialysis visit for one of two residents in the survey sample that received dialysis services; Resident #91. The findings include: For Resident #91, there were no dialysis communication sheets for 8/31/23, 9/2/23 and 9/9/23; and incomplete dialysis communication sheets for 8/29/23 and 9/5/23. The facility policy, "Hemodialysis" was reviewed. This policy documented, "Guests/residents receiving hemodialysis will be assessed pre and post treatment, and receive necessary interventions....4. The facility completes the appropriate section of the hemodialysis communication form prior to guest/resident receiving each dialysis session and again when the guest/resident returns from hemodialysis..." A review of the clinical record revealed an order dated 8/21/23 for dialysis on Monday, Wednesday, and Friday; and an order dated 8/30/23 changing the dialysis days to Tuesday, Thursday and Saturday. A nurse's note dated 8/27/23 that documented, "....Guest notified writer that his dialysis has	F 698	1. Resident #91 no longer resides in the facility. 2. Residents having dialysis will be audited to ensure communication is completed for each resident on dialysis days. 3. Licensed nurses will be re-educated on completing dialysis communication sheets on residents who go to dialysis by October 9, 2023 by the ADON/ Designee. 4. DON/designee will conduct audits of residents who attend dialysis 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure communication sheets are completed. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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changed to Tue, Thur and Sat (Tuesday, Thursday, Saturday) starting on Tue 8/29/2023...." This is in support of the above order changing the dialysis days.

The information was not included on the dialysis communication sheet from the dialysis center to the facility on 8/25/23. It is not documented if this change was initiated by the dialysis center on 8/25/23 or by the resident in the days following dialysis on 8/25/23.

A review of the dialysis communication log revealed the communication sheet dated 8/29/23 did not contain any communication from the dialysis center to the facility and did not contain the resident's name to validate that it was even for this resident.

The dialysis sheet dated 9/5/23 did not contain the resident's name to validate that it was applicable for this resident.

Further review revealed there was no communication sheets dated 8/31/23, 9/2/23 and 9/9/23.

On 9/12/23 at 4:10 PM, an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that there should be completed communication sheets for every visit so that each facility knows what is going on with the resident.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4 (Registered Nurse), the unit manager. She stated that dialysis communication sheets should be completed for each visit by the facility and the dialysis center.

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F 698	Continued From page 60 On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided. On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700		10/16/23

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F 700	Continued From page 61 by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure all bed rail requirements were met for one of 37 residents in the survey sample, Resident #87. The findings include: For Resident #87 (R87), the facility staff failed to review the risks and benefits of bed rails with the resident and obtain informed consent. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/1/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R87's clinical record revealed a physician's order dated 2/17/23 for a right assist bar (bed rail) to aide in turning and repositioning. A physical device evaluation dated 2/20/23 documented the use of an assist bar enabled increased bed mobility and enabled the resident to reposition self. On 9/11/23 at 2:48 p.m., R87 was observed lying in bed with a right assist bar in the upright position. On 9/12/23 at 1:49 p.m., an interview was conducted with R87. When asked, the resident stated that the facility staff had not explained the risks and benefits of the assist bar until about an hour before the interview when a staff member had the resident sign a form.	F 700	1. Resident #87 immediately had a review of the risks and benefits of bed rails and signed consent for grab bars. 2. Residents with grab bars will be audited to ensure they have had risks and benefits of bed rails reviewed and have a signed consent for grab bars. Any resident noted not to have a sign consent will be implemented. 3. Licensed Nurse will be re-educated on ensuring a review of the risks and benefits bed rails and signed consent for grab bars has been completed by October 9, 2023 by the ADON/ designee. 4. DON/designee will conduct audits of residents with grab bars 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure a review of the risks and benefits of bed rails and signed consent for grab bars has been. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations	

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	495257	A. BUILDING _____ B. WING _____	C 09/13/2023

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F 700	Continued From page 62 On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the nurses have to get special permission for residents to use assist bars and someone in the nursing department should educate residents about the use of assist bars and obtain informed consent. On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Side Rail/Bed/Mattress Spacing and Mechanical Requirements" documented, "2. If a side rail is implemented the facility must obtain informed consent from the resident or if applicable, the resident representative for the use of side rails."	F 700		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 725		10/16/23

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F 725	Continued From page 63 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, it was determined that the facility staff failed to maintain sufficient nursing staff to ensure a resident's needs were met for one of 37 residents in the survey sample, Resident #24. The findings include: For Resident #24 (R24) the facility staff failed to provide incontinence care due to insufficient nursing staff. R24 was admitted to the facility with diagnoses that included but were not limited to: muscle wasting and abnormalities of gait and mobility. On 09/11/23 at 12:35 p.m., an observation revealed that R24, who resided on the west unit at the facility, activated the call bell for incontinence care. On 09/11/23 at 12:45 p.m., an observation revealed CNA (certified nursing assistant) #2 entered R24's room, turned off the call and left the room with R24's lunch tray.	F 725	1. Facility is now providing adequate staffing to ensure resident needs are met. 2. A meeting will be conduct to review the master schedule to ensure staffing to meet residents need. 3. DON and Staffing Coordinator will be re-educated by October 9, 2023 to ensure staffing is adequate to provide nursing care to meet the residents□ needs by the Administrator/designee. 4. Administrator/designee will conduct audits of nursing staff 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure staffing is adequate to provide nursing care to residents. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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F 725	Continued From page 64	F 725		

On 09/11/2023 at 1:00 p.m., an observation revealed LPN (licensed practical nurse) #4 entered R24's room and provided incontinence care.

The facility's as-worked schedule for 09/11/2023 documented eight certified nursing assistants were scheduled for the 7:00 a.m. to 3:00 p.m. shift, four on the west unit and four on the east unit.

On 09/11/23 at 12:57 p.m., an interview was conducted with R24. When asked about CNA #2 entering her room R24 stated that she told CNA #2 that she was wet and needed to be cleaned.

On 09/12/23 at approximately 1:06 p.m., an interview was conducted with CNA (certified nursing assistant) #2. When asked about her entering R24's room at approximately 12:45 p.m., the day before, she stated that she picked up R24's meal tray and that R24 asked if she would clean her up. CNA #2 stated that she told R24 that when she finished picking up the meal trays she would come back and provide incontinence care. When asked what time she finished picking up the meal trays, CNA #2 stated that it was after 1:00 p.m. but could not recall the exact time. When asked why R24 had to wait for incontinence care CNA #2 stated that the unit was short staffed and that there were three CNAs for 60 residents.

On 09/12/2023 at approximately 4:16 p.m., an interview was conducted with CNA #1, staffing coordinator. When asked to describe the minimal staffing requirements to provide adequate and consistent resident care CNA #1 stated that with

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F 725	Continued From page 65 the facility census there should be six CNAs on the west unit and six CNAs on the east unit during the 7:00 a.m. to 3:00 p.m. shift and two LPNs (licensed practical nurses) on each unit during the 7:00 a.m. to 3:00 p.m. shift. When asked about the staffing on Monday, 09/11/2023, she stated that there were four CNAs on each of the units, and explained that the facility has had CNAs drop to prn (as needed) status, some have been terminated and CNAs call out. When asked how she addresses the short staffing CNA #1 stated that she calls staff who are off trying to get them to come in to cover and that the facility does not use agency staff. When asked if not enough staff having effects the quality of resident care she stated yes. On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		10/16/23

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F 732	Continued From page 66 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post daily nurse staffing information prior to the start of the shift on two of three survey dates. The findings include: The facility staff failed to post nurse staffing information on 9/11/2023 and 9/12/2023 prior to the beginning of the nursing staff work shift.	F 732	1. Posted nurse staffing information is being posted daily. 2. No other concern noted. 3. Staffing coordinator and DON will be re-educated on posting nurse staffing information daily by October 9, 2023, by the Administrator/designee. 4. Administrator will conduct audits of posted nurse staffing information 3 times	

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F 732	Continued From page 67 On 9/11/2023 at 2:19 p.m., an observation was made of the facility's lobby which revealed the staff posting dated 9/7/2023. On 9/11/2023 at 4:30 p.m., an observation was made of the facility's lobby which revealed the staff posting dated 9/7/2023. On 9/12/2023 at 8:19 p.m., an observation was made of the facility's lobby which revealed the staff posting dated 9/7/2023. On 9/12/2023 at 10:00 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the scheduling coordinator posted the staffing each day when they arrived. She stated that the scheduling coordinator had been working on the floor as an aide so she and the administrator had been assisting to post the staffing. She stated that they filled out a daily staffing sheet from the master schedule and posted it at the front desk in the lobby each morning. She stated that the daily staff posting should be posted each day. ASM #2 was made aware of the observations of the staff posting dated 9/7/2023 observed on 9/11/2023 and 9/12/2023 and stated that she was aware. The facility policy, "Required Regulatory Postings" revised 4/19/2022 documented in part, "...The facility posts the total number and actual hours worked of licensed and unlicensed nursing staff directly responsible for guest/resident care for each shift. The information will be displayed in a prominent location that is clearly visible and accessible by guests/residents, family and staff... Posting Requirements i. The facility will post the data specified above on a daily basis at the beginning of each shift..."	F 732	weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure nurse staffing information is posted daily. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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F 732	Continued From page 68 On 9/12/2023 at approximately 5:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator, were made aware of the concern. No further information was presented prior to exit.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		10/16/23

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F 755	Continued From page 69 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide pharmacy services for one of 37 residents in the survey sample, Resident #310. The findings include: For Resident #310 (R310), the facility staff failed to ensure multiple medications were available for administration on multiple dates in February 2023. A review of R310'S clinical record revealed a physician's order dated 2/17/23 for alpha-lipoic acid (1) 300 mg (milligrams)- one capsule by mouth one time a day for supplement. A review of R310's February 2023 MAR (medication administration record) revealed the same physician's order for alpha-lipoic acid. On 2/18/23, 2/19/23, 2/20/23, 2/22/23, 2/23/23 and 2/24/23, the MAR documented the code, "5=Hold/See Nurse Notes." A nurse's note dated 2/18/23 documented the staff was waiting for delivery of the medication. A nurse's note dated 2/19/23 documented the medication was not available. A nurse's note dated 2/20/23 documented the medication was held until available. A nurse's note dated 2/22/23 documented the staff was waiting for delivery of the medication. A nurse's note dated 2/23/23 documented the pharmacy stated insurance would not pay for the medication and the facility had to pay. A nurse's note dated 2/24/23 documented the medication was not available.	F 755	1. Resident #310 no longer resides in the facility. 2. An audit will be conduct of the MARs of the prior 30 days for not administered medications. Providers will be notified of any missed medications. 3. Licensed nurses will be re-educated by October 9, 2023 on the process of obtaining medications from the pharmacy and the procedures on when the medications are not readily available by the ADON/designee. 4. DON/designee will conduct audits of the MAR for not administered medications in the clinical meeting 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure medications are given in accordance with written orders of the provider. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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Further review of R310's clinical record revealed a physician's dated 2/17/23 for Flonase (2) nasal suspension 50 mcg (micrograms)- one spray in both nostrils two times a day for allergy. A review of R310's February 2023 MAR revealed the same physician's order for Flonase. For the morning doses on 2/18/23 and 2/22/23, the MAR documented the code, "5=Hold/See Nurse Notes." A nurse's note dated 2/18/23 documented the medication was in route from the pharmacy. A nurse's note dated 2/22/23 documented the medication was in route from the pharmacy and would be given at the next administration time.

Further review of R310's clinical record revealed a physician's order dated 2/20/23 for Mirabegron (3) 25 mg- one tablet by mouth two times a day for bladder spasms. A review of R310's February 2023 MAR revealed the same physician's order for Mirabegron. For the morning doses on 2/21/23 and 2/22/23, the MAR documented the code, "5=Hold/See Nurse Notes." A nurse's note dated 2/22/23 documented the staff was waiting for delivery of the medication from the pharmacy.

A review of the facility backup medication supply list revealed alpha-lipoic acid, Flonase, and Mirabegron were not available in the supply.

On 9/12/23 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated if a medication is newly ordered, the medication should be pulled from the backup medication supply, and if the medication is not available in the supply, then the nurses should call the pharmacy and ask for the medication to be sent STAT (immediately).

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F 755	Continued From page 71 On 9/12/23 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Medication Administration" documented, "Medications are administered in accordance with written orders of the attending physician." The facility pharmacy policy titled, "Providing Pharmacy Products and Services" documented, "Pharmacy will provide Facility with the Facility-specific information sheet set forth in the "Facility-Specific Information Sheet which details how Facility staff can contact Pharmacy twenty four (24) hours a day, seven (7) day a week." References: (1) "People most commonly use alpha-lipoic acid for nerve pain in people with diabetes." This information was obtained from the website: https://medlineplus.gov/druginfo/natural/767.html (2) Flonase is used to relieve allergies. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695002.html (3) Mirabegron is used to treat overactive bladder. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a612038.html	F 755		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		10/16/23

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F 757	Continued From page 72 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure residents were free from unnecessary medications for four of 37 residents in the survey sample; Residents #100, #88, #91, and #7. The findings include: The facility policy, "Anticoagulant Therapy" was reviewed. This policy documented, "Anticoagulant therapy is utilized as a prophylaxis and treatment of venous thrombosis, pulmonary embolism, thrombotic disorders, Atrial-Fibrillation with embolism and prophylaxis of systemic embolism after Myocardium Infarction. They inhibit the development of a thrombus....5. Throughout anticoagulant therapy monitor the guest/resident for signs and symptoms of	F 757	1 Resident #7 order for tramadol has been changed to scheduled. Resident #100, Resident #88 and Resident #91 no longer reside in the facility. 2 An audit will be conducted on residents who are administered PRN pain medications to ensure MD orders with parameters are being followed and include non-pharmacological intervention are offered/attempted. An audit will also be conducted on residents on anti-coagulants to ensure orders include monitoring of anti-coagulant for side effects, to include bleeding and bruising. 3 Licensed Nurses will be re-educated by October 9, 2023 regarding residents who are administered PRN pain medications	

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F 757	Continued From page 73 bleeding. If signs and symptoms of bleeding are noted, hold anticoagulant medication and notify physician immediately." 1. For Resident #100, the facility staff failed to monitor for the use of an anticoagulant medication. A review of the clinical record revealed an order dated 8/25/23 for Eliquis (1) 5 mg (milligrams) twice daily for seven days; and an order dated 9/2/23 for Eliquis 5 mg once daily. A review of the comprehensive care plan revealed one dated 8/25/23 for "(Resident #100) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant." This care plan included the intervention, dated 8/25/23 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician" and one dated 8/25/23 for "Observe and report to physician PRN (as-needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds." Further review of the clinical record failed to reveal any evidence of nurses monitoring for the use of an anticoagulant medication side effects related to risk of bleeding and bruising and other side effects.	F 757	MD orders with parameters are followed and include non-pharmacological intervention are offered/attempted and documented and residents on anti-coagulants MD orders include monitoring of anti-coagulant for side effects, to include bleeding and bruising by the ADON/designee. 4 DON/designee will conduct audits of the MAR of residents with PRN pain and anti-coagulants medications in the daily clinical meeting, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure PRN pain medications MD orders with parameters are being followed and documented non-pharmacological intervention are offered/ attempted prior to administering PRN pain medication and anti-coagulant have MD orders and documentation of anti-coagulant being monitored for side effects, to include bleeding and. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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On 9/13/23 at 8:35 AM, an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that nurses should "watch for bruising, bleeding, things like that." She stated that monitoring should be throughout the day, not just a one-time check. She stated that it should be documented in the nurse's notes if there are or are not any signs and symptoms and to let the nurse practitioner know if there are any. She stated that if there isn't an order for monitoring, you can ask the doctor and put it in yourself.

On 9/13/23 at 8:46 AM, an interview was conducted with LPN #7. She stated that nurses should watch for bruising of any kind, coughing up blood, bleeding profusely from a wound or unusual places, change in condition. She stated that evidence of monitoring is done by charting on progress notes and a skin note. She stated that there should be a note every day even if nothing occurred so others will know what has been going on with the resident.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4 (Registered Nurse), the unit manager. She stated that each shift should be monitoring for side effects of anticoagulant medications. She stated that there should be documentation of the monitoring. She stated that she cannot say it is being monitored; if it is not documented it is not done.

On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.

Reference:

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(1) Eliquis - "Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed."
Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

2. For Resident #88, the facility staff failed to monitor for the use of an anticoagulant medication.

A review of the clinical record revealed an order dated 8/5/23 for Apixaban (1) (same as Eliquis) 5 mg (milligrams) twice daily for atrial fibrillation.

A review of the comprehensive care plan revealed one dated 3/20/23 for "(Resident #88) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant." This care plan included the intervention, dated 3/20/23 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician" and one dated 3/20/23 for "Observe and report to physician PRN (as-needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in

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stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds."

Further review of the clinical record failed to reveal any evidence of nurses monitoring for the use of an anticoagulant medication side effects related to risk of bleeding and bruising and other side effects.

On 9/13/23 at 8:35 AM, an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that nurses should "watch for bruising, bleeding, things like that." She stated that monitoring should be throughout the day, not just a one-time check. She stated that it should be documented in the nurse's notes if there are or are not any signs and symptoms and to let the nurse practitioner know if there are any. She stated that if there isn't an order for monitoring, you can ask the doctor and put it in yourself.

On 9/13/23 at 8:46 AM, an interview was conducted with LPN #7. She stated that nurses should watch for bruising of any kind, coughing up blood, bleeding profusely from a wound or unusual places, change in condition. She stated that evidence of monitoring is done by charting on progress notes and a skin note. She stated that there should be a note every day even if nothing occurred so others will know what has been going on with the resident.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4 (Registered Nurse), the

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unit manager. She stated that each shift should be monitoring for side effects of anticoagulant medications. She stated that there should be documentation of the monitoring. She stated that she cannot say it is being monitored; if it is not documented it is not done.

On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.

Reference:
(1) Eliquis - "Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed."
Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

3. For Resident #91, the facility staff failed to monitor for the use of an anticoagulant medication.

A review of the clinical record revealed a physician's order dated 9/11/23 for Coumadin (1)

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5 mg (milligrams) daily, on Monday, Tuesday, Wednesday, Thursday, and Friday; and an order dated 9/11/23 for Coumadin 9.5 mg Saturday and Sunday, for atrial fibrillation.

A review of the comprehensive care plan revealed one dated 8/21/23 for "(Resident #91) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant." This care plan included the intervention, dated 8/21/23 for "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician" and one dated 8/21/23 for "Observe and report to physician PRN (as-needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds."

Further review of the clinical record failed to reveal any evidence of nurses monitoring for the use of an anticoagulant medication side effects related to risk of bleeding and bruising and other side effects.

On 9/13/23 at 8:35 AM, an interview was conducted with LPN #6 (Licensed Practical Nurse). She stated that nurses should "watch for bruising, bleeding, things like that." She stated that monitoring should be throughout the day, not just a one-time check. She stated that it should be documented in the nurse's notes if there are or are not any signs and symptoms and to let the

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nurse practitioner know if there are any. She stated that if there isn't an order for monitoring, you can ask the doctor and put it in yourself.

On 9/13/23 at 8:46 AM, an interview was conducted with LPN #7. She stated that nurses should watch for bruising of any kind, coughing up blood, bleeding profusely from a wound or unusual places, change in condition. She stated that evidence of monitoring is done by charting on progress notes and a skin note. She stated that there should be a note every day even if nothing occurred so others will know what has been going on with the resident.

On 9/13/23 at 11:00 AM, an interview was conducted with RN #4 (Registered Nurse), the unit manager. She stated that each shift should be monitoring for side effects of anticoagulant medications. She stated that there should be documentation of the monitoring. She stated that she cannot say it is being monitored; if it is not documented it is not done.

On 9/13/23 at 11:23 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided.

Reference:
(1) Coumadin - "Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a

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vein) and pulmonary embolism (a blood clot in the lung)."
Information obtained from https://medlineplus.gov/druginfo/meds/a682277.html
4. For R7, the facility staff failed to administer a prn (as needed) the pain medication Tramadol (1) within the physician ordered pain level parameters.

R7 was admitted with diagnosis that included but not limited to osteoarthritis of the knee (2).

The physician order for R7 documented in part, "Tramadol HCl (hydrochloride) Tablet 50 MG (milligrams). Give 1 (one) tablet by mouth every 8 (eight) hours as needed for Pain level 6-10. Order Date: 10/25/2022."

The eMAR (electronic medication administration record) for R7 dated August 2023 documented the physician order as stated above. Further review of the eMAR revealed that (R7) received 50 mgs of Tramadol for a pain level of five on 08/01/2023, 08/03/2023, 08/05/2023, 08/06/2023, 08/07/2023, 08/15/2023, 08/23/2023, 08/27/2023 and on 08/31/2023.

The eMAR for R7 dated September 2023 documented the physician order as stated above. Further review of the eMAR revealed that (R7) received 50 mg of Tramadol for a pain level of five on 09/03/2023, 09/06/2023 and on 09/08/2023.

On 09/13/2023 at approximately 11:00 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. After reviewing the physician order, and the August

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F 757	Continued From page 81 2023 and September 2023 eMARS she was asked if the pain medication for R7 was administered according to the physician's orders for the dates listed above. ASM #2 stated no, and that the medication was administered outside of the physician's ordered parameters. On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Tramadol is used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. (2) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips, or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.	F 757		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced	F 800		10/16/23

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F 800	Continued From page 82 by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide a diet to meet a resident's needs for one of 37 residents in the survey sample, Resident #310. The findings include: For Resident #310 (R310), the resident was discharged from the hospital on 2/17/23 with a recommendation for a diabetic diet. The facility staff failed to obtain a physician's order for R310's diet until 2/20/23. R310 was served a regular diet until a physician's order for a consistent carbohydrate diet with no added salt was obtained on 2/20/23. A hospital orthopedic surgery progress note dated 2/16/23 documented, "Assessment/Plan: Diet: diabetic..." R310 was admitted to the facility on 2/17/23 with a diagnosis of diabetes. A review of R310's physician's orders failed to reveal any dietary orders until 2/20/23. A dietary communication form dated 2/18/23 documented the resident's diet as regular. A facility form titled, "Guest/Resident, Family, Employee, and Visitor Assistance Form" dated 2/20/23 documented, "What is your concern about? Diet. I am diabetic...When did the problem or incident occur? Since 2/17/23. FACILITY RESPONSE: Dietary received a new admission slip for guest on 2/18/23 which is a Saturday, diet slip stated guest was a regular diet. ACTION TO BE TAKEN: Dietary director will go see guest for food preferences..." A registered	F 800	1. Resident #310 no longer resides in the facility. 2. Resident diets will be audited to ensure residents are receiving meals per MD orders. Any resident's diet noted not following MD orders will be corrected immediately. 3. Licensed nurse will be re-educated by October 9, 2023 on providing dietary with the diet order per MD orders upon resident□s admission to the facility by the ADON/ designee. 4. DON/designee will conduct audits on diet communication per MD orders to ensure dietary serves the correct diet per MD orders 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

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dietician nutritional evaluation dated 2/20/23 documented, "Utilizes insulin pump for DM (diabetes mellitus) management, follows a strict CHO (carbohydrate) counting diet for DM..." Further review of R310's clinical record revealed a physician's order dated 2/20/23 for a consistent carbohydrate diet with no added salt.

On 9/12/23 at 4:59 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated that when a resident is admitted to the facility, the nurses usually obtain the resident's diet order from the hospital, are told the diet order during the phone report from the hospital, or the nurses will look through the hospital discharge paperwork which will usually indicate the diet the resident should be provided. RN #3 stated the nurses are responsible for entering the diet order into the computer system and providing a diet communication form to the kitchen on the day of admission.

On 9/13/23 at 8:19 a.m., an interview was conducted with OSM (other staff member) #4 (the registered dietician). OSM #4 stated that on the day of admission, the nurses are supposed to enter a diet order into the computer system, and this is usually the diet that the hospital staff has placed the resident on. OSM #4 stated that within a week, she evaluates the resident and changes the diet order if needed. OSM #4 stated she evaluated R310 on 2/20/23 and a consistent carbohydrate diet with no added salt was prescribed on that date. OSM #4 stated this was equivalent to a diabetic diet.

On 9/13/23 at 9:01 a.m., an interview was conducted with OSM (other staff member) #5 (the former dietary manager). OSM #5 stated

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F 800	Continued From page 84 residents' prescribed diets are communicated from the nursing staff to the dietary staff via dietary communication forms. OSM #5 stated the diet that is documented on the communication form and provided to the kitchen is the diet that is entered into the dietary meal tracker system and the diet that is provided. On 9/13/23 at 3:07 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Diet Orders" documented, "1. The Nurse will obtain a Physician order for the type of diet needed upon admission/readmission and when a diet change is needed. 2. The Nurse or Designee will provide a written Diet Order and Communication form of the change to the Dietary department."	F 800		
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. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		10/16/23

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

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F 812	Continued From page 85 §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 observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner in one of one facility kitchens. The findings include: The facility staff failed to close a box containing a bag of breaded fish filets, exposing them to the environment, in one of one walk-in freezers. On 09/11/2023 at approximately 11:45 a.m., an observation of the facility's walk-in freezer was conducted with OSM (other staff member) #1, dietary manager. Observation of the middle shelf on the right side inside the freezer revealed a ten-pound box of breaded fish filets. Observation of the box revealed that the box and the inside packaging was open to the environment. When asked how much was left in the box OSM #1 stated it about half remaining. OSM #1 further stated that the box should have been closed and immediately removed it from the freezer. The facility's policy "Food Purchasing and Storage" documented in part, "All frozen food will be dated, labeled, and wrapped or sealed. Moisture-proof, tightfitting materials will be used to prevent freezer burn." On 09/12/2023 at approximately 5:07 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional	F 812	1. The box of fish noted to be not sealed appropriately was thrown away immediately. 2. An audit of the kitchen will be conduct to ensure proper food storage to include the walk-in freezer. 3. Dietary staff will be re-educated by October 9, 2023 on the proper storage of food in the walk-in freezer by the dietary manager/designee. 4. Dietary Manager/designee will conduct audits of storage of food in the walk-in freezer 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure food is stored appropriately. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 86 clinical coordinator, were made aware of the above findings. No further information was provided prior to exit.	F 812		