STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495086	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY POINTE REHABILITATION AND NURSING	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

(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 08/22/23 through 08/24/23. 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 8/22/23 through 8/24/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The census in this 112 certified bed facility was 105 at the time of the survey. The survey sample consisted of 30 current resident reviews and three 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 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.	F 550		10/8/23

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

Electronically Signed | 09/18/2023

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F 550	Continued From page 1 §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, facility document review, and clinical record review, the facility staff failed to maintain a resident's dignity for one of 33 residents in the survey sample, Resident #6. The findings include: For Resident #'6 (R6), the facility staff failed to store R6's urinary catheter collection bag in a privacy cover.	F 550	1. Resident #6 was immediately provided and currently has a privacy foley bag. 2. The nursing management team audited residents with catheters for presence of privacy bags, no other deficiencies were observed. 3. On 8/24/23 education for nursing staff was initiated on the Promoting/Maintaining Resident Dignity to ensure residents with foleys have privacy covers. Certified and licensed nursing staff will receive	

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F 550	Continued From page 2 On the following dates and times, R6 was observed. At each observation, her urinary catheter collection bag with urine in it was without a privacy cover, and was visible to anyone who passed by: 8/22/23 at 1:58 p.m. (resident sitting up in bed); 8/23/23 at 9:09 a.m. (resident sitting up in bed); 8/23/23 at 12:51 p.m. (resident self-propelling in her wheelchair in the hallway by the central desk). On 8/23/23 at 1:58 p.m., R6 was interviewed. When asked if she was bothered by the catheter collection bag, she stated: "I guess I haven't thought about it. But it would be nice if everyone couldn't see my [urine] in the bag." A review of R6's care plan dated 10/23/19 revealed, in part: "[R6] is s/p (status/post) suprapubic catheter replacement...position catheter bag and tubing below the level of the bladder and away from the entrance room door." On 8/24/23 at 11:30 a.m., LPN (licensed practical nurse) #7 was interviewed. When asked if urinary collection bags should be positioned or stored in any special way, she stated: "They should have some kind of privacy cover." She stated the facility used to keep the in stock, but she was not sure if that was the case at the current time. She stated an exposed urinary collection bag does not promote a resident's dignity. On 8/24/23 at 2:28 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were informed of these concerns. A review of the facility policy, "Promoting/Maintaining Resident Dignity,"	F 550	education. 4. An audit of residents with catheters will be conducted weekly x4 weeks, then monthly x1 month by the unit manager/designee to ensure residents with catheters have privacy covers. Results of the audit will be submitted to QAPI committee monthly to determine effectiveness of plan of correction 5. Facility will be in compliance by 10/8/23.	

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F 550	Continued From page 3 revealed, in part: "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality...Maintain resident privacy." No further information was provided prior to exit.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		10/8/23

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F 584	Continued From page 4 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to maintain a clean, comfortable, and homelike environment for two of 33 residents in the survey sample, Residents #32 and #106. The findings include: 1. For Resident #32 (R32), the facility staff failed to maintain the resident's room in a clean and homelike manner. Trash was observed and remained on the floor beside the bed from 8/22/23 through 8/24/23 and a film of dust was observed on the resident's dressers from 8/22/23 through 8/24/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/17/23, 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.	F 584	1. Trash and dust were immediately removed from resident #32 room. Resident #106 bathroom was immediately deep cleaned, removing stains and dirt. 2. Residents□ rooms were observed, and any affected areas were cleaned per facilities expectations. 3. Housekeeping staff and department managers will be educated by 10/8/23 on Safe and Homelike Environment policy to ensure facility expectations for cleanliness in residents rooms and bathrooms are met 4. A weekly audit of resident rooms will be conducted by the Environmental Services Manager/designee for the cleanliness of rooms and bathrooms x3 then monthly x2. The results of the audit will be presented to QAPI committee monthly to determine effectiveness of plan of correction 5. Facility will be in compliance by 10/8/23.	

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F 584	Continued From page 5	F 584		

On 8/22/23 at 1:27 p.m., an interview was conducted with R32. The resident voiced concern regarding dirt and trash on the floor by the bed, and dust on the dressers. R32 stated the housekeepers clean the room most of the time, but there have been times the room hasn't been cleaned for five days, and sometimes the room isn't cleaned on the weekends. R32 stated that when the housekeeping employees do clean the room, they are not good and thorough. At this time, three yellow foam pieces (less than an inch in diameter), a stack of plastic cups and a Ziplock bag was observed on the floor beside the bed. Also, a film of dust was observed on the resident's dressers. On 8/23/23 at 2:58 p.m., and 8/24/23 at 8:29 a.m., the trash remained on R32's floor and the dust remained on the dressers.

On 8/24/23 at 9:07 a.m. an interview was conducted with OSM (other staff member) #1 (the environmental services director). OSM #1 stated resident rooms should be swept and mopped every day, and all surfaces in resident rooms should be cleaned every day. On 8/24/23 at 9:18 a.m., an observation of R32's room was conducted with OSM #1. OSM #1 stated the trash and dust was not acceptable, and this was not clean, comfortable, and homelike.

On 8/24/23 at 2:31 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Safe and Homelike Environment" documented, "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment..."

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F 584	Continued From page 6	F 584		

2. For Resident #106 (R106), the facility staff failed to maintain the resident's bathroom in a clean and homelike manner. Black stains were observed on the floor, along the perimeter of the walls, and black dirt and hairs were observed around the base of the toilet from 8/22/23 through 8/24/23.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/10/23, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 8/22/23 at 1:21 p.m., an interview was conducted with R106. R106 voiced concern about black stains on the floor, along the perimeter of the walls in the bathroom, and black substance around the base of the toilet. R106 stated the resident voiced concern about the floor to someone a couple of months before, but the floor was still dirty. At this time, R106's bathroom was observed. Black stains were observed on the floor, along the perimeter of the walls, and black substance and hairs was observed around the base of the toilet. On 8/23/23 at 3:03 p.m. and 8/24/23 at 8:33 a.m., black stains remained on the floor, and black substance and hairs remained around the base of the toilet.

On 8/24/23 at 9:07 a.m., an interview was conducted with OSM (other staff member) #1 (the environmental services director). OSM #1 stated resident bathrooms should be cleaned every day and this cleaning should include sweeping the floor, mopping the floor, cleaning the tub, wiping the mirrors, and cleaning the toilet. On 8/24/23 at

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F 584	Continued From page 7 9:22 a.m., R106's bathroom was observed with OSM #1. OSM #1 stated the base around the toilet should be part of daily cleaning. OSM #1 further stated the floor would have to be scrubbed, and she was working on a list of rooms that needed this. OSM #1 stated R106's bathroom was not clean, comfortable, and homelike. On 8/24/23 at 2:31 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		10/8/23

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F 623	Continued From page 8	F 623		

resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 9 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide written notification to the Office of the State Long-Term Care Ombudsman of a hospital transfer for one of 33 residents in the survey sample; Resident #67.	F 623	1. There were no adverse effects from this deficiency. On 9/18/23 notification of transfer of resident #67 was sent to the ombudsman. 2. Residents who transfer/discharge from the facility have the potential to be	

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F 623	Continued From page 10 The findings include: For Resident #67, the facility staff failed to send the ombudsman written notification of transfers to the hospital. A review of the clinical record revealed that on 6/30/23, Resident #67 was sent to the emergency room for abdominal pain; and on 7/3/23 for chest pain. Further review of the clinical record failed to reveal any evidence of a written notification to the ombudsman of the hospital transfers. A review of the fax that was sent to the ombudsman on 7/4/23 for June 2023 transfers and discharges failed to reveal Resident #67's name as being transferred on 6/30/23. A review of the fax that was sent to the ombudsman on 8/1/23 for the July 2023 transfers and discharges failed to reveal Resident #67's name as being transferred on 7/3/23. On 8/24/23 at 11:24 AM, when ASM #1 (Administrative Staff Member, the Administrator) provided the above two fax lists, she stated that Resident #67 was not on the list for ombudsman notification for the hospital transfers on 6/30/23 and 7/3/23 because the resident went to the emergency room and back to the facility on the same day and therefore was not captured on the discharge report that is printed and provided to the ombudsman for the notification each month. She stated that she called the ombudsman to inquire his expectation and that he did not expect notifications under these circumstances.	F 623	affected. 3. The social services director was educated by the Administrator on the requirements of notifying the ombudsman of emergency transfers/discharges. 4. Admin/designee will conduct an audit of discharges and transfers to ensure notifications were sent weekly x4 and then monthly x1. The results of the audit will be presented to QAPI committee monthly to determine effectiveness of plan of correction 5. Facility will be in compliance by 10/8/23	

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F 623	Continued From page 11 The regulations do not identify exceptions to the ombudsman notification requirement. A facility policy for hospital transfers/ombudsman notification was requested however none was provided.	F 623		
F 641 SS=E	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 resident interview, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide an accurate MDS (minimum data set) assessment for five out of 33 residents in the survey sample, Residents ##11, #62, #57, #32 and #111. The findings include: 1. For Resident #11, the facility staff failed to complete an accurate MDS (minimum data set); annual assessment for anticoagulant use. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/17/23, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. Section N- Medications: coded the resident anticoagulant-"yes."	F 641	1. The MDS assessments for Residents #11, #62, #32, #57, #111, were immediately re opened and corrected for re submission. 2. The last 30 days of assessments for discharged patients were evaluated for accuracy and correction if needed. Current residents using Trulicity, and anticoagulant medication were reviewed for accurate coding on the MDS. 3. The DON/designee will educate MDS staff on accurate drug class and coding for Trulicity and anticoagulants. 4. Administrator/designee will audit 5 random MDS assessments weekly x4 then monthly x2 for accurate coding specifically for insulin, anticoagulants, and discharge information. The results of this audit will be presented to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	10/8/23

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BAY POINTE REHABILITATION AND NURSING	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

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A review of the physician orders dated 1/4/23 revealed, "Clopidogrel Bisulfate Tablet 75 milligram po every morning." Clopidrel (Plavix) is classified as an antiplatelet.

On 8/23/23 at 2:30 PM, an interview was conducted with LPN (licensed practical nurse) #3, the MDS coordinator. When asked to verify the coding Resident #11's 8/17/23 Section N: anticoagulant, LPN #3 stated, yes, it is incorrectly coded. It should have been coded anticoagulant 'no'. When asked what standard is followed for completing a MDS, LPN #3 stated, the RAI (resident assessment instrument) manual.

On 8/23/23 at approximately 4:00 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #4, the regional director of operations was made aware of the findings.

No further information was provided prior to exit.

2. For Resident #62, the facility staff failed to complete an accurate MDS (minimum data set); annual assessment for anticoagulant use.

The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 7/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section N- Medications: coded the resident anticoagulant-"no."

A review of the physician orders dated 6/30/23 revealed, "Eliquis (anticoagulant) Oral Tablet 5 milligram (mg). Give 5 mg by mouth two times a

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day."

On 8/24/23 at 12:05 PM, an interview was conducted with LPN (licensed practical nurse) #3, the MDS coordinator. When asked to verify the coding for Resident #62's 7/6/23 Section N: anticoagulant, LPN #3 stated it was coded as a no. After looking at the physician orders and medication administration record LPN #3 stated, "It was incorrectly coded on the 7/6/23 [MDS], anticoagulant should have been coded 'yes'." When asked what standard is followed for completing a MDS, LPN #3 stated, the RAI (resident assessment instrument) manual.

On 8/24/23 at approximately 2:30 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #4, the regional director of operations was made aware of the findings.

No further information was provided prior to exit.
3. For Resident #32 (R32), the facility staff failed to accurately code section N of the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/17/23. R32 was coded as having received insulin seven out of the last seven days however the resident did not receive insulin.

A review of Resident #32's physician's order summary for August 2023 failed to reveal any orders for insulin but did contain an order dated 5/25/23 for Trulicity 0.75 milligrams/0.5 milliliters-inject one dose subcutaneously every Friday for diabetes mellitus. Section N0350 of R32's quarterly MDS with an ARD of 8/17/23 coded the resident as having received insulin seven out of the last seven days.

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On 8/23/23 at 1:46 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the MDS coordinator). LPN #3 stated that since Trulicity was a subcutaneous injection for diabetes, she assumed the medication was insulin.

The Trulicity website documented the drug classification for this medication as a glucagon-like peptide-1 (GLP-1) receptor agonist used to treat diabetes. This information was obtained from the website: https://uspl.lilly.com/trulicity/trulicity.html#s3.

On 8/23/23 at 4:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

4. For Resident #57 (R57), the facility staff failed to accurate code section N of the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 6/14/23. R57 was coded as having received insulin seven out of the last seven days however the resident did not receive insulin.

A review of R57's physician's order summary for August 2023 failed to reveal any orders for insulin but did contain an order dated 12/6/22 for Trulicity 1.5 milligrams/0.5 milliliters-inject 1.5 milligrams every Thursday for diabetes mellitus. Section N0350 of R57's quarterly MDS with an ARD of 6/14/23 coded the resident as having received insulin seven out of the last seven days.

On 8/23/23 at 1:46 p.m., an interview was conducted with LPN (licensed practical nurse) #3

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(the MDS coordinator). LPN #3 stated that since Trulicity was a subcutaneous injection for diabetes, she assumed the medication was insulin.

The Trulicity website documented the drug classification for this medication as a glucagon-like peptide-1 (GLP-1) receptor agonist used to treat diabetes. This information was obtained from the website: https://uspl.lilly.com/trulicity/trulicity.html#s3.

On 8/23/23 at 4:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

5. For Resident #111 (R111), the facility staff failed to accurately code the resident's discharge status on the resident's discharge MDS (minimum data set) assessment with an ARD (assessment reference date) of 6/21/23. The staff coded R111 discharged to an acute hospital, but the resident discharged to another nursing home.

R111 discharged from the facility on 6/21/23. A social services note dated 6/21/23 documented R111 was discharging to another nursing facility for long term care services. Section A2100 of R111's discharge MDS with an ARD of 6/21/23 coded the resident discharged to, "03. Acute hospital."

On 8/23/23 at 1:46 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the MDS coordinator). LPN #3 stated she coded R111's discharge MDS wrong and needed to make a correction. LPN #3 stated she references

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F 641	Continued From page 16 the CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) manual when completing MDS assessments. The CMS RAI manual documented, "A2100: OBRA Discharge Status Steps for Assessment 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Coding Instructions Select the 2-digit code that corresponds to the resident's discharge status. ·Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds..." On 8/23/23 at 4:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.	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 §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	F 656		10/8/23

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F 656	Continued From page 17 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- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the	F 656	1. Resident #68 care plan reviewed and revised for keeping their fingernails short. Resident #89 care plan was reviewed and	

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facility staff failed to develop and/or implement the comprehensive care plan for seven of 33 residents in the survey sample, Residents #68, #89, #39, #22, #62, #25 and #101.

The findings include:

1. For Resident #68 (R68), the facility staff failed to implement the comprehensive care plan to keep their fingernails short.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/3/2023, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The assessment documented R68 requiring extensive assistance of one person for bathing and personal hygiene.

The comprehensive care plan for R68 documented in part, "The resident has potential/actual impairment to skin integrity r/t (related to) fragile skin. Date Initiated: 01/09/2023. Revision on: 01/09/2023." Under "Interventions" it documented in part, "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Date Initiated: 01/09/2023..."

On 8/22/2023 at 4:10 p.m., R68 was observed in bed asleep with their hands visible on top of the blanket. The fingernails on both hands were observed to be approximately one-quarter inch long.

On 8/23/2023 at 8:36 a.m., an interview was conducted with R68 in their room. When asked if

revised to reflect psychotropic medication use. Resident #39 care plan was reviewed and revised to monitor for adverse effects daily of psychotropic medication used. Resident #22 care plan was reviewed and revised to reflect the use of side rails and for the facility to provide a meal to take to dialysis. Resident #62 care plan was reviewed and revised to reflect the use of anticoagulant medication regimen. Resident # 25 care plan was reviewed and revised to reflect diagnosis of PTSD. Resident #101 care plan was reviewed and revised to reflect diagnosis of schizoaffective disorder.
2. A care plan audit for residents currently on psychotropic medication, anticoagulant medication, residents with side rails, and residents going to dialysis will be completed to ensure their care plans are accurate and will be revised as needed.
3. The interdisciplinary team was educated by the DON on 9/5/23 on the Comprehensive Care Plan and Care Plan Revisions Upon Status change policies to ensure the facility develops and implements accurate comprehensive care plans for residents in a timely manner.
4. the DON/Designee will audit each resident who admits to the facility for completion and accuracy of comprehensive care plans weekly x4 weeks then monthly x2. The results of this audit will be submitted to the QAPI committee monthly to determine effectiveness of plan of correction
5. Facility will be in compliance by10/8/23.

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they performed nail care themselves, R68 stated "No." When asked if the nursing staff trimmed their fingernails, R68 stated "No." R68 proceeded to show the nails on the right hand and open up their left hand to show the nails further. R68 stated that they were long and "Need cutting." The third and fourth nail on the left hand were observed to be long, uneven and jagged on the edges. All of the fingernails were observed to be approximately one-quarter inch long.

On 8/23/2023 at 2:14 p.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that they trimmed resident's fingernails as needed. She stated that residents fingernails were assessed for trimming on shower days and as needed and cleaned underneath daily.

On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the CNA staff should be assessing the fingernails daily when providing ADL (activities of daily living) care to residents and trim them as needed. She stated that the purpose of the care plan was so the staff could have direction of what the goals of the patient were and that it was integrated so they could all see what the goals were and the whole plan of care. She stated that the care plan should be implemented so that they provided the best outcome and care for the patient and so everyone was on the same page. She observed R68's fingernails and stated that they were long and needed to be trimmed. She stated that the staff may have overlooked the nails needing trimming due to R68 being more independent in some parts of their care. She asked R68 if she could

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trim the fingernails and they stated "Thank you."

The facility provided policy "Care planning Special Needs-Dialysis" revised 12/1/2022, failed to evidence guidance on implementing the care plan. The policy documented in part, "...Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures..."

The facility policy "Activities of Daily Living (ADLs)" revised 12/1/2022, documented in part, "...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..."

On 8/23/2023 at 4:00 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

2. For Resident #89 (R89), the facility staff failed to develop the comprehensive care plan to include psychotropic medication use.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/13/2023, the resident scored 6 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The assessment documented R89 receiving an antidepressant six of the seven days during the assessment period.

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The physician orders for R89 documented in part, "Sertraline HCl (1) Oral Tablet 50 MG (milligram) (Sertraline HCl) Give 1.5 tablet by mouth one time a day for Anxiety 75 mg. Order Date: 04/13/2023."

The comprehensive care plan for R89 failed to evidence documentation of the use of an antidepressant medication.

On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the purpose of the care plan was so the staff could have direction of what the goals of the patient were and that it was integrated so they could all see what the goals were and the whole plan of care. She stated that any nurse or the MDS staff could update the care plan.

On 8/24/2023 at 12:10 p.m., an interview was conducted with LPN #3, MDS coordinator. LPN #3 stated that the MDS staff were responsible for creating the care plan and the nursing staff helped with updating and adding to the care plans. She stated that upon admission they did a baseline care plan and then after the MDS assessment was completed, the comprehensive care plan was developed. She stated that there were certain medications that should be addressed on the care plan such as antidepressants. She reviewed R89's care plan and stated that the antidepressant should be addressed on the care plan and they did not see it.

On 8/24/2023 at 2:27 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional

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director of operations were made aware of the above concern.

No further information was presented prior to exit.

Reference:
(1) Sertraline is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness. Sertraline is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amounts of serotonin, a natural substance in the brain that helps maintain mental balance. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a697048.html

3. For Resident #39 (R39), the facility staff failed to implement the comprehensive care plan to monitor for adverse effects daily from psychotropic medications.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/9/2023, the resident scored 10 out of 15 on the BIMS (brief interview for

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mental status), indicating the resident was moderately impaired for making daily decisions. The assessment documented R39 receiving an antidepressant seven of the seven days during the assessment period and an antianxiety medication seven of seven days during the assessment period.

The physician orders for R39 documented in part, "Buspirone HCl (1) Tablet 10 MG (milligram) Give 1 tablet by mouth three times a day for depression. Order Date: 07/25/2023... Amitriptyline HCl (2) Tablet 150 MG Give 1 tablet by mouth at bedtime for depression. Order Date: 07/25/2023... Escitalopram Oxalate (3) Tablet 20 MG Give 1 tablet by mouth one time a day for Depression. Order Date: 07/25/2023..."

The comprehensive care plan for R39 documented in part, "(Name of R39) has use of psychotropic medications r/t (related to) antidepressant, anxiety. Date Initiated: 01/23/2020. Revision on: 02/20/2020." Under "Interventions" it documented in part, "... Monitor for adverse effects daily. Notify MD (medical doctor) prn (as needed) and document. Date Initiated: 01/23/2020." The care plan further documented "The resident uses antidepressant medication (SPECIFY medications) r/t Depression. Date Initiated: 10/28/2022. Revision on: 04/21/2023." Under "Interventions" it documented in part, "Administer Antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness Q-Shift (every shift). Date Initiated: 10/28/2022. Revision on: 04/21/2023..." The care plan also documented, "The resident uses anti-anxiety medication r/t Anxiety disorder. Date Initiated: 10/29/2022. Revision on: 04/21/2023." Under

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"Interventions" it documented in part, "Administer Anti-Anxiety medications as ordered by physician. Monitor for side effects and effectiveness Q-Shift. Date Initiated: 10/29/2022. Revision on: 04/21/2023..."

The eMAR (electronic medication administration record) for R39 dated 7/1/2023-7/31/2023 and 8/1/2023-8/31/2023 failed to evidence psychotropic medication monitoring for R39.

On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that there was a prompt on the eMAR where they documented behavior and side effect monitoring of psychotropic medications. She stated that monitoring was done every shift and documented on the eMAR. She stated that the purpose of the care plan was so the staff could have direction of what the goals of the patient were and that it was integrated so they could all see what the goals were and the whole plan of care. She stated that the care plan should be implemented so that they provided the best outcome and care for the patient and so everyone was on the same page. She reviewed R39's eMAR and stated that she did not see the behavior monitoring and side effect monitoring on the eMAR.

On 8/23/2023 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the executive director for evidence of behavior and side effect monitoring for R39.

On 8/24/2023 at 10:03 a.m., ASM #2, the director of nursing stated that they did not have any behavior or side effect monitoring to provide for R39 and they had placed an order to start

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documenting the monitoring now.

On 8/24/2023 at 2:27 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional director of operations were made aware of the above concern.

No further information was presented prior to exit.

Reference:
(1) Buspirone is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety. Buspirone is in a class of medications called anxiolytics. It works by changing the amounts of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html

(2) Amitriptyline is used to treat symptoms of depression. Amitriptyline is in a class of medications called tricyclic antidepressants. It works by increasing the amounts of certain natural substances in the brain that are needed to maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682388.html

(3) Escitalopram is used to treat depression in adults and children and teenagers 12 years of ago or older. Escitalopram is also used to treat generalized anxiety disorder (GAD; excessive worry and tension that disrupts daily life and lasts for 6 months or longer) in adults, teenagers, and children 7 years of age and older. Escitalopram is in a class of antidepressants called selective

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serotonin reuptake inhibitors (SSRIs). It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603005.html

4. For Resident #22, the facility staff failed to develop a care plan for the use of side rails, and failed to implement the care plan to include providing a meal to take to dialysis appointments.

4.a. Resident #22 was admitted to the facility on 3/11/22 with diagnoses that included but were not limited to: bilateral BKA (below the knee amputation).

Resident #22 was observed in bed with 1/2 side rails on 8/22/23 at 3:50 PM and on 8/23/23 at 10:45 AM.

A review of the comprehensive care plan dated 3/21/22, which revealed, "FOCUS: The resident is High risk for falls related to Confusion, Deconditioning, Gait/balance problems and Hypotension. INTERVENTIONS: Anticipate and meet the resident's needs." There was no evidence of bed rail use on the care plan.

A review of the facility's "Bed Rail Safety Review" dated 9/11/22 and 6/23/23, revealed, "List bed rail(s) to be implemented: half rails. List side(s): both."

There were no physician order for the bed rails.

On 8/23/23 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4.

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When asked the purpose of the care plan, LPN #4 stated, the purpose is to provide everyone the plan of care for the resident. When asked who is responsible for developing the care plan, LPN #4 stated, the MDS coordinator initiates the care plan. When asked if bed rails should be on the care plan, LPN #4 stated, yes, it should be.

On 8/24/23 at 12:05 PM, an interview was conducted with LPN #3, the MDS coordinator. When asked who is responsible for initiating care plans, LPN #3 stated, it is my responsibility.

On 8/24/23 at approximately 2:30 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #4, the regional director of operations was made aware of the findings.

No further information was provided prior to exit.

4. b. For Resident #22, the facility staff failed to implement the care plan to include providing a meal to take to dialysis appointments.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/11/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section O- Special Procedures/Treatments: coded the resident dialysis-yes.

A review of the comprehensive care plan dated 3/21.22, which revealed, "FOCUS: The resident needs dialysis type hemo/peritoneal related to renal failure. The resident is at nutrition and/or

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hydration risk due to diagnosis of ESRD. INTERVENTIONS: HD (hemodialysis) every Monday-Wednesday-Friday. Monitor and record pre and post wt. Provide, serve Regular-CCHO-NAS (carbohydrate controlled no added salt) diet with Double Protein at all meals, as ordered. Monitor intake and record each meal."

On 8/23/23 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked the purpose of the care plan, LPN #4 stated, the purpose is to provide everyone the plan of care for the resident. When asked who is responsible for developing the care plan, LPN #4 stated, the MDS coordinator initiates the care plan. When asked if Resident #22 was not receiving a bagged sandwich and drink to take to dialysis, was the dialysis care plan implemented, LPN #4 stated, no, it is not implemented.

On 8/24/23 at approximately 2:30 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #4, the regional director of operations was made aware of the findings.

No further information was provided prior to exit.

5. For Resident #62, the facility staff failed to develop a care plan for the use of an anticoagulant.

Resident #62 was admitted to the facility on 6/29/23 with diagnosis that included but were not limited to: long-term anticoagulant use.

The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with

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an ARD (assessment reference date) of 7/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section N- Medications: coded the resident anticoagulant-no.

A review of the physician orders dated 6/30/23 revealed, "Eliquis Oral Tablet 5 milligram (mg). Give 5 mg by mouth two times a day."

A review of the comprehensive care plan dated 7/24/23, which revealed, "FOCUS: The resident has a behavior problem related to Major Depressive Disorder and Heart Failure. INTERVENTIONS: Anticipate and meet the needs of resident." There was no evidence of anticoagulant use on the care plan.

On 8/23/23 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked the purpose of the care plan, LPN #4 stated, the purpose is to provide everyone the plan of care for the resident. When asked who is responsible for developing the care plan, LPN #4 stated, the MDS coordinator initiates the care plan. When asked if anticoagulants should be on the care plan, LPN #4 stated, yes, it should be. When asked why it should be on the care plan, LPN #4 stated, so the team knows to assess for bleeding and bruising and report it immediately.

On 8/24/23 at 12:05 PM, an interview was conducted with LPN #3, the MDS coordinator. When asked who is responsible for initiating care plans, LPN #3 stated, "It is my responsibility."

On 8/24/23 at approximately 2:30 PM, ASM (administrative staff member) #1, the executive

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director, ASM #2, the director of nursing, ASM #4, the regional director of operations was made aware of the findings.

A review of the facility's "High Risk Medication" policy, revealed, "The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants include: a. Bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine or stool) b. Fall in hematocrit or blood pressure c. Thromboembolism 5. The resident's plan of care shall include interventions to minimize risk of adverse consequences. Examples include (depending on the medication): a. Limit venipunctures and injections, as possible. Be aware of the need to apply pressure following these procedures. b. Use soft toothbrush and electric razors. Limit intake of foods high in vitamin K: broccoli, cabbage, collard greens, spinach, kale, turnip greens, and brussel sprouts. d. Avoid cranberry juice and cranberry products. e. Caution resident/family about alcohol use while taking anticoagulants. f. Educate resident/family on risks of bleeding, dietary modifications, and symptoms to report to nurse/physician. g. Avoid (strenuous) activities that may lead to injury."

No further information was provided prior to exit.
6. For Resident #25 (R25), the facility staff failed to develop a care plan for the resident's diagnosis of PTSD (post-traumatic stress disorder) (1).

R#25's admitting diagnoses included PTSD (1). A review of R25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/11/23, R25's diagnoses list included PTSD.

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A review of R25's care plan revealed no information related to interventions for PTSD.

On 8/24/23 at 9:32 a.m., OSM (other staff member) #3, the director of social services, was interviewed. She stated R25 should have a care plan for PTSD. She stated she was not sure who was responsible for developing this care plan.

On 8/24/23 at 11:36 p.m., LPN (licensed practical nurse) #3, the MDS coordinator, was interviewed. She stated she is responsible for developing a resident's comprehensive care plan, with input from "the whole team." When asked if R25 should have a care plan for PTSD, she stated: "That is a good question. I wouldn't unless the resident was demonstrating behaviors." She stated just because a resident has a diagnosis of PTSD, "we don't need to give the staff assumptions about it."

On 8/24/23 at 2:28 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were informed of these concerns. ASM #2 stated the MDS coordinator is responsible for developing the care plan to address a resident's needs.

No further information was provided prior to exit.

NOTES
(1) "Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event...Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger." This information is taken from the website

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https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.

7. For Resident #101 (R101), the facility staff failed to develop a care plan for the resident's diagnosis of schizoaffective disorder (1).

R#101's admitting diagnoses included schizoaffective disorder (1). A review of R101's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/5/23, R101's diagnoses list included schizoaffective disorder.

A review of R101's care plan revealed no information related to interventions for schizoaffective disorder.

On 8/24/23 at 11:36 p.m., LPN (licensed practical nurse) #3, the MDS coordinator, was interviewed. She stated she is responsible for developing a resident's comprehensive care plan, with input from "the whole team." When asked if R101 should have a care plan for schizoaffective disorder, she stated: "Maybe." She stated it depended on the resident's current status.

On 8/24/23 at 2:28 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were informed of these concerns. ASM #2 stated the MDS coordinator is responsible for developing the care plan to address a resident's needs.

No further information was provided prior to exit.

Reference:
(1)"Schizoaffective disorder is a mental condition

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F 656	Continued From page 33 that causes both a loss of contact with reality (psychosis) and mood problems (depression or mania)." This information is taken from the website https://medlineplus.gov/ency/article/000930.htm.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 657	1. Resident #68 care plan revised	10/8/23

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F 657	Continued From page 34 review, the facility staff failed to review and revise the comprehensive care plan for three of 33 residents in the survey sample, Residents #7, #68 and #89. The findings include: 1. For Resident #68 (R68), the facility staff failed to revise the comprehensive care plan to include the use of bed rails. The comprehensive care plan for R68 documented in part, "The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Hemiplegia. Date Initiated: 04/15/2022. Revision on: 08/15/2022." The care plan failed to evidence bed rail usage. On 8/22/2023 at 4:10 p.m., an observation was made of R68 in their room. R68 was observed in bed asleep with bilateral upper bed rails in place. Additional observations of R68 in bed with bilateral bed rails in place were made on 8/23/2023 at 8:36 a.m. and 2:20 p.m. The clinical record documented a bed rail assessment and consent dated 4/9/2023. On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the purpose of the care plan was so the staff could have direction of what the goals of the patient were and that it was integrated so they could all see what the goals were and the whole plan of care. She stated that nursing staff and MDS staff updated the care plan. She stated that bed rail use should be addressed on the care plan.	F 657	immediately to reflect the usage of side rails. Resident #89 care plan updated immediately to reflect the correct code status. Resident #7 care plan reviewed and revised based on current plan of care. 2. Residents are at risk when their care plan is not revised to reflect current needs timely. 3. The interdisciplinary team was educated by the DON on 9/5/23 on the Comprehensive Care Plan and Care Plan Revisions Upon Status change policies to ensure the facility develops and implements accurate comprehensive care plans for residents in a timely manner. 4. The DON/designee will audit 5 random care plans a week for accurate revisions x4weeks then monthly x1. The results of this audit will be submitted to the QAPI committee monthly to determine effectiveness of plan of correction 5. Facility will be in compliance by 10/8/23.	

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On 8/23/2023 at 4:00 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

2. For Resident #89 (R89), the facility staff failed to revise the comprehensive care plan to update the advance directive/code status.

The comprehensive care plan for R89 documented in part, "Advance Directive - (Name of R89) is Full Code. Date Initiated: 12/19/2022. Revision on: 03/26/2023."

The physician orders for R89 documented in part, "ADC: DNR (do not resuscitate). Order Date: 06/28/2023."

The clinical record contained a durable do not resuscitate order form dated 6/27/2023 for R89 signed by the physician and the resident representative.

On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the purpose of the care plan was so the staff could have direction of what the goals of the patient were and that it was integrated so they could all see what the goals were and the whole plan of care. She stated that nursing staff and MDS staff updated the care plan. She stated that she would expect the code status to be updated on the care plan when the code status was changed. She stated that the process would be to put in the order and then update the care plan after the proper paperwork

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was signed. She reviewed R89's care plan and stated that the code status had not been updated there and should have been to reflect the DNR status.

On 8/23/2023 at 4:00 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

3. For Resident #7, the facility staff failed to review and revise the resident's comprehensive care plan when a male resident touched the resident's breast on 7/12/22.

A facility synopsis of events documented that on 7/12/22, an employee witnessed a male resident touching himself and fondling R7's breast. A review of R7's comprehensive care plan revised on 12/9/22 failed to reveal the care plan was reviewed and revised regarding the 7/12/22 event.

On 8/23/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated, "The purpose of the care plan is so we can have direction of what the goals of the patient are, it is integrated so we can all see what the goals are, the whole plan of care."

On 8/24/23 at 9:42 a.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 stated R7's care plan should have been reviewed and revised when the resident's breast was fondled because this was an event that happened to the resident.

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F 657	Continued From page 37 On 8/24/23 at 2:31 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a policy regarding care plans.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review, staff interview and facility document review, it was determined the facility staff failed to follow professional standards of practice for medication administration for one of 33 residents in the survey sample, Resident #89. The findings include: For Resident #89 (R89), the facility staff failed to ensure medications were ingested and not left at the bedside in a medication cup unattended. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/13/2023, the resident scored 6 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. On 8/22/2023 at 2:17 p.m., an observation was	F 658	. Medication was not administered to the resident and was discarded upon discovery. The physician assistant assessed Resident #8 and resident had no adverse impact from medication at bedside. 2. On 8/23/23 the SDC completed an audit of residents rooms and found no unauthorized residents with medications at bedside. 3. On 8/23/23 education for nursing staff was initiated by the Director of Nursing/Designee on the Medication Administration policy regarding not leaving medication at bedside unless specifically ordered by the physicians. Nursing staff will receive education. 4. Director of Nursing or designee will perform an audit of 10 random residents 3x weekly to ensure there are no medications at bedside unless	10/8/23

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F 658	Continued From page 38 made of R89 in their room. R89 was observed in bed watching television. A small clear plastic medication cup approximately 30 ml (milliliter) in size was observed sitting on the overbed table to the right of R89. Inside of the plastic cup were seven pills of various shapes and colors. When asked about the cup, R89 stated that they were their medications and they were going to take them later. R89 stated that someone had left them for her that morning and they would take them later. The physician orders for R89 failed to evidence an order to leave medications at the bedside for self-administration. The comprehensive care plan for R89 failed to evidence documentation of self-administration of medications. The clinical record failed to evidence documentation of R89's ability to self-administer medications. On 8/22/2023 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that medications were not supposed to be left at the bedside. She stated that R89 was not able to self-administer medications and should be observed taking medications prior to them leaving the room. She observed the clear plastic medication cup with the seven pills inside on top of R89's overbed table in the room and stated that she thought they were her morning medications. She stated that the medications should not be left in the room because they may not be able to be taken at a later time, may cause adverse effects if taken later or anyone could come in a pick them up.	F 658	physician□s order is in place then monthly x2. Any areas of concern will be immediately reported to the medical director. This audit will be presented to QAPI committee monthly to determine effectiveness of plan of correction 5. Facility will be in compliance by 10/8/23 .	

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F 658	Continued From page 39 The facility policy "Medication Administration" revised 12/1/2022 documented in part, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection... 15. Observe resident consumption of medication..." On 8/23/2023 at 4:00 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to provide ADL (activities of daily living) care to a dependent resident for one of 33 residents in the survey sample, Resident #68. The findings include: For Resident #68 (R68), the facility staff failed to trim their fingernails.	F 677	1. Resident #68 nails were trimmed immediately. No adverse effects were noted. 2. Current residents nails were observed and trimmed as needed. There were no adverse effects for any residents upon completion of the inspection. 3. On 8/23/23 education for nursing staff was initiated by the Director of Nursing/Designee on the Activities of Daily Living regarding grooming expectations of residents nails. Nursing	10/8/23

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F 677	Continued From page 40 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/3/2023, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The assessment documented R68 requiring extensive assistance of one person for bathing and personal hygiene. On 8/22/2023 at 4:10 p.m., R68 was observed in bed asleep with their hands visible on top of the blanket. The fingernails on both hands were observed to be approximately one-quarter inch long. On 8/23/2023 at 8:36 a.m., an interview was conducted with R68. When asked if they performed nail care themselves, R68 stated "No." When asked if the nursing staff trimmed their fingernails, R68 stated "No." R68 proceeded to show the nails on the right hand and open up their left hand to show the nails further. R68 stated that they were long and "Need cutting." The third and fourth nail on the left hand were observed to be long, uneven and jagged on the edges. All of the fingernails were observed to be approximately one-quarter inch long. The comprehensive care plan for R68 documented in part, "The resident has potential/actual impairment to skin integrity r/t (related to) fragile skin. Date Initiated: 01/09/2023. Revision on: 01/09/2023." Under "Interventions" it documented in part, "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Date Initiated: 01/09/2023..."	F 677	staff will receive education. 4. The DON/designee will complete a weekly audit of residents nails x4 and monthly x2. The results of this audit will be submitted to QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	

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F 677	Continued From page 41 On 8/23/2023 at 2:14 p.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that they trimmed resident's fingernails as needed. She stated that residents fingernails were assessed for trimming on shower days and as needed and cleaned underneath daily. On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the CNA staff should be assessing the fingernails daily when providing ADL care to residents and trim them as needed. She observed R68's fingernails and stated that they were long and needed to be trimmed. She stated that the staff may have overlooked the nails needing trimming due to R68 being more independent in some parts of their care. She asked R68 if she could trim the fingernails and they stated "Thank you." The facility policy "Activities of Daily Living (ADLs)" revised 12/1/2022, documented in part, "...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..." On 8/23/2023 at 4:00 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/8/23

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F 695	Continued From page 42 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to store respiratory equipment in a sanitary manner for two of 33 residents The findings include: 1. For Resident #6 (R6), the facility staff failed to store nebulizer equipment in a sanitary manner. On 8/22/23 at 1:58 p.m., and 8/23/23 at 9:09 a.m. and 12:52 p.m., R6's nebulizer tubing and mouthpiece were observed lying in direct contact with R6's nebulizer machine; there was no covering on the tubing or the mouthpiece. A review of R6's orders revealed the following order dated 5/18/23: "Ipratropium-Albuterol Inhalation Solution 0.5-2.5 MG/3ML (milligrams/milliliter) (Ipratropium-Albuterol) 1 application inhale orally every 6 hours for SOB (shortness of breath)." A review of R6's August 2023 MAR (medication administration record) revealed the resident received the medication as ordered. On 8/24/23 at 10:21 a.m., LPN (licensed practical	F 695	1. Resident #6 nebulizer equipment was immediately stored in a sanitary manner. Resident # 32 incentive spirometer was immediately stored in a sanitary manner. 2. On 8/24/23, residents who have nebulizers and incentive spirometers were observed by the SDC with their equipment stored properly. 3. On 8/23/23 education for nursing staff was initiated by the Director of Nursing/Designee on the Cleaning and Disinfection of Resident-Care Equipment policy regarding the importance of properly storing nebulizer equipment and incentive spirometers. Nursing staff will receive education. 4. The DON/designee will complete a weekly audit of residents on nebulizers and who use an incentive spirometer to ensure equipment is stored in a sanitary manner x4 weeks then monthly x2. The results of this audit will be submitted to the QAPI committee monthly to determine effectiveness of plan of correction 5. Facility will be in compliance by 10/8/23.	

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nurse) #6, a unit manager, was interviewed. When asked where the tubing and mouthpiece for a nebulizer should be stored, she stated: "There should be a clear bag for it. It should be stored in a plastic bag." She stated storage in a plastic bag would prevent the nebulizer equipment from touching dirty surfaces.

On 8/24/23 at 11:30 a.m., LPN #7 was interviewed. She stated nebulizer mouthpieces and tubing should be stored in a clear, protective bag to prevent contamination.

On 8/24/23 at 2:28 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were informed of these concerns.

A review of the facility policy, "Cleaning and Disinfection of Resident-Care Equipment," revealed, in part: "Semi-critical items are exposed to mucous membranes (i.e. [for example] respiratory equipment) or non-intact skin." The policy did not contain information about the storage of respiratory equipment.

No further information was provided prior to exit.
2. For Resident #32 (R32), the facility staff failed to store an incentive spirometer in a sanitary manner.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/17/23, 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 R32's clinical record revealed a

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physician's order dated 5/22/23 to document the total minutes of direct resident bedside care for incentive spirometer medication administration-12-15 breaths, total of 15-20 minutes.

On 8/22/23 at 1:27 p.m., 8/23/23 at 1:24 p.m. and 8/24/23 at 8:29 a.m., an uncovered incentive spirometer with the mouthpiece exposed to air was observed sitting on R32's dresser. On 8/22/23 at 1:27 p.m., R32 stated they sometimes uses the incentive spirometer. On 8/24/23 at 8:29 a.m., R32 stated the staff have never provided a cover for the incentive spirometer.

On 8/24/23 at 8:55 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated incentive spirometers should be stored by the bedside so residents can use them. LPN #2 stated she did not have a particular "thing" to cover incentive spirometers, but maybe something could be used for germs. LPN #2 stated incentive spirometers definitely need to be wiped down, and the nurses wipe incentive spirometers down, but there is not a set schedule or documentation that this is done.

On 8/24/23 at 10:22 a.m., R32 stated staff do not wipe down or clean the incentive spirometer.

On 8/24/23 at 2:31 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Cleaning and Disinfection of Resident-Care Equipment" did not document specific information regarding incentive spirometers.

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F 698	Continued From page 45	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 33 residents in the survey sample, Resident #22. The findings include: The facility failed to provide a bagged lunch for Resident #22 to take with him to the dialysis appointment. Resident #22 was admitted to the facility on 3/11/22 with diagnosis that included but were not limited to: ESRD (end stage renal disease), dialysis, and diabetes mellitus. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/11/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. Section O- Special Procedures/Treatments: coded the resident dialysis-yes.	F 698	1. Resident #22 was not adversely affected by not receiving a bagged lunch for dialysis and received a meal upon arrival back to the facility after dialysis. 2. On 8/25/23, other dialysis residents were reviewed and interviewed by the SDC about receiving a bagged lunch for dialysis and there were no other discrepancies found. 3. On 8/23/23 education for nursing and dietary staff was initiated by the Director of Nursing/Designee on the Care Planning Special Needs- Dialysis policy and process regarding providing a bagged meal for residents who leave the facility for dialysis services. Nursing and dietary staff will receive education. 4. The DON/designee will conduct a weekly audit to ensure bagged lunches are provided to the resident to take with them x4 weeks then monthly x2. The results of this audit will be submitted to the QAPI committee monthly to determine effectiveness of plan of correction 5. Facility will be in compliance by 10/18/23.	10/8/23

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A review of the comprehensive care plan dated 3/21.22, which revealed, "FOCUS: The resident needs dialysis type hemo/peritoneal related to renal failure. The resident is at nutrition and/or hydration risk due to diagnosis of ESRD. INTERVENTIONS: HD (hemodialysis) every Monday-Wednesday-Friday. Monitor and record pre and post wt. Provide, serve Regular-CCHO-NAS (carbohydrate controlled no added salt) diet with Double Protein at all meals, as ordered. Monitor intake and record each meal."

A review of the physician's order dated 3/2/23, revealed, "Outpatient hemodialysis: Days Scheduled: Monday, Wednesday, Friday. Chair time 6:00am."

An interview was conducted on 8/22/23 at 3:45 PM with Resident #22, when asked what items he took with him to dialysis, Resident #22 stated, "There is a book I take." When asked if he takes a bagged meal, Resident #22 stated, "Not for the last week. They used to send me with a sandwich and drink." Resident #22 stated they did not take one on 8/21/23.

An interview was conducted on 8/22/23 at 4:15 PM with LPN (licensed practical nurse) #1. When asked what is sent with a resident who goes to dialysis, LPN #1 stated, we send a communication book with all his current information. When asked if a bagged meal is sent with the resident, LPN #1 stated, there have not been any bagged meal for him the last few days. He goes to dialysis early, so the bagged meal would need to get sent up in the evening.

An interview was conducted on 8/24/23 at 10:15

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AM with Resident #22. When asked if they had taken a bagged meal with them to dialysis on 8/23/23, Resident #22 stated, no, there was no food.

An interview was conducted on 8/24/23 at 10:30 AM with OSM (other staff member) #8, the dietary manager. When asked if brown bag meal was provided to Resident #22 for his dialysis appointments, OSM #8 stated, "Yes, we provide a bagged meal. For this resident who leaves about 5:30 AM, we send the bagged meal up the evening before with the evening snacks. We have been sending them up."

On 8/24/23 at approximately 2:30 PM, ASM #1, the executive director, ASM #2, the director of nursing, ASM #4, the regional director of operations was made aware of the findings.

According to the facility's "Care Planning Special Needs-Dialysis" policy reveals, "This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving dialysis. Interventions will include, but not limited to a. Documentation and monitoring of complications b. Pre- and post-weights c. Assessing, observing, and documenting care of access sites, as applicable d. Nutrition and hydration, including the provision of meals and snacks on treatment days. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day, and as needed."

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F 698	Continued From page 48 No further information was provided prior to exit.	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 by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence documentation of a current bed rail assessment and consent, for one of 33 residents in the survey sample, Residents #109. The findings include:	F 700	1. Resident #109 was immediately assessed for the use of bedrails and consent for the use was obtained. 2. On 8/24/23 the maintenance director audited resident rooms to confirm who had bed rails in use and reported it to the administrator. The DON/designee reviewed the list and completed assessments and consents for any like	10/8/23

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F 700	Continued From page 49 For Resident #109 (R109), the facility failed to evidence a consent for the use of bed rails and a bed rail assessment. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/26/2023, the resident scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired to make daily decisions. The resident was coded as being totally dependent on two or more persons for bed mobility and transfers. On 8/22/2023 at 1:51 p.m., an observation was made of R109 in bed with bilateral bar shaped bed rails in place in the up position on the upper portion of the bed. At this time an interview was conducted with R109. R109 stated that they used the bed rails to grab onto during care provided by facility staff. R109 stated that they had the rails on the bed since admission and wanted them on the bed. Additional observations of R109 in bed with the bilateral bar shaped bed rails in place were made on 8/22/2023 at 3:44 p.m. and 8/23/2023 at 9:23 a.m. The nursing admission assessment dated 7/22/2023 for R109 documented in part, "Side Rails: Sides: Both. Rails: Half. Indicated to promote independence with bed mobility..." The assessment failed to evidence a consent obtained for use of bed rails, alternatives used prior to bed rails, and a review of the risks and benefits of bed rails with the resident and/or the resident representative.	F 700	residents. The maintenance director was instructed to remove any bed rails that should not have been in place which was completed immediately. No residents were adversely affected. 3. On 8/24/23 education for nursing staff was initiated by the Director of Nursing/Designee on the regulation on required assessments and consents for use of bed rails. 4. The DON/designee will conduct weekly audits on bedrails in use to ensure there is an appropriate assessment and consent in place weekly x4 weeks then monthly x2. The results of this audit will submitted to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	

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The nursing admission assessment dated 8/15/2023 for R109 documented in part, "Side Rails: Sides: Both. Rails: Half..." The assessment failed to evidence a consent obtained for use of bed rails, alternatives used prior to bed rails, indication for use and a review of the risks and benefits of bed rails with the resident and/or the resident representative.

On 8/23/2023 at approximately 4:00 p.m., a request was made via written list to ASM (administrative staff member) #1, the executive director, for evidence of the bed rail assessment and consent for use of bed rails for R109.

On 8/24/2023 at 9:35 a.m., ASM #2, the director of nursing stated that they did not have a bed rail assessment for R109. She stated that the bed rail assessment was triggered by the admission assessment and they did not consider the grab bars that R109 had bed rails.

On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the bed rail assessment was completed during the admission assessment. She stated that the nurse assessed the resident to see if they could safely use the bed rails to assist in turning or positioning themselves prior to putting them in place and they obtained a verbal consent from the resident or the family and documented it in the clinical record. She reviewed R109's admission assessment and clinical record and stated that she did not see a bed rail assessment or consent and there should be one because they used the bed rails to grab on to during care.

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F 700	Continued From page 51 On 8/24/2023 at 2:27 p.m., ASM #1, the executive director, ASM #2, the director of nursing, and ASM #4, the regional director of operations were made aware of the findings. No further information was provided prior to exit.	F 700		
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. (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	F 732		10/8/23

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F 732	Continued From page 52 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 staff interview, clinical record review and facility document review, it was determined the facility staff failed to post daily staffing for one of three days reviewed. The findings include: The facility staff failed to post the nurse staffing data on a daily basis at the beginning of each shift. The facility shifts were 7 AM-3 PM, 3 PM-11 PM, 11 PM-7 AM, and at times, 7 AM-7 PM and 7 PM-7 AM. On 8/22/23 at 11:45 AM upon entrance to the facility for the survey, the bulletin board in the main lobby had staffing posted with a date of 8/22/23 on posting. On 8/23/23 at 8:00 AM, the daily staffing posted on the bulleting board in the main lobby was dated 8/22/23; at 8:35 AM, the date remained 8/22/23. On 8/23/23 at 10:00 AM, the date was 8/23/23. The daily staffing was posted correctly on 8/24/23 at 8:00 AM. On 8/23/23 at 9:00 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When	F 732	1. The receptionist was immediately educated on the timeliness of posting the staffing information sheet. 2. Residents have the right to review current and timely staffing information. 3. On 8/24/23 the DON educated the business office manager, day time receptionist, and evening and weekend receptionist on the Facility Required Posting policy regarding the regulation of posting the staffing information sheet prior to the start of the shift. A new process was implemented to ensure that the night receptionist post the following day□s staffing information before leaving. 4. The DON/designee will conduct weekly audits on the time the staffing sheet is posted x4 weeks then monthly x2. The results of this audit will be submitted to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	

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F 732	Continued From page 53 asked to describe the staff posting process, ASM #2 stated, they have centralized staffing and the daily staffing form is emailed to us the evening before. The receptionist posts the daily staffing form in the evening prior to the next day. On 8/23/23 at 10:00 AM, an interview was conducted with OSM (other staff member) #1, the receptionist. When asked to describe the staff posting process, OSM #1 stated, "It is emailed the evening before. I work till 4:00 PM and if it is not emailed by then, it is posted the next day. When asked what time the daily staffing is posted, OSM #1 stated, it is posted by 8:00 AM. On 8/24/23 at approximately 2:30 PM, ASM #1, the executive director, ASM #2, the director of nursing, ASM #4, the regional director of operations was made aware of the findings. According to the facility's "Facility Required Posting" policy revised 12/22, "The facility will post required postings in an area that is accessible to all staff and residents. The facility must also post the following: Staffing Information." No further information was provided prior to exit.	F 732		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 745	1. Resident #7 was visited by social	10/8/23

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F 745	Continued From page 54	F 745		

and clinical record review, the facility staff failed to provide medically related social services for one of 33 residents in the survey sample, Resident #7.

The findings include:

For Resident #7, the facility staff failed to assess and monitor the resident's psychosocial well-being after a male resident fondled the resident's breast on 7/12/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/3/23, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions.

A facility synopsis of events documented that on 7/12/22, an employee witnessed a male resident touching himself and fondling R7's breast. The residents were immediately separated, the male resident was placed on two-hour checks, and discharged on 7/14/22. The synopsis of events documented a skin check was completed for all residents (including R7), and R7 would be monitored for changes in behavior. A review of R7's clinical record (including assessments, progress notes, the medication administration record, and the treatment administration record for July 2022) failed to reveal documentation regarding the 7/12/22 event, and any evidence that R7 was assessed for and monitored for any psychosocial concerns.

On 8/24/23 at 9:42 a.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 stated that if

worker and evaluated for any psychosocial needs on 8/25/23.
2. Residents may be at risk when their psychosocial needs are not addressed.
3. On 8/25/23 the administrator reviewed the social worker□s job description with the facility□s social worker, specifically on trauma informed care and the social worker□s role in identifying and care planning trauma informed care. each resident with social, emotional, and psychological needs.
4. The Administrator/designee will conduct weekly audits of like incidents occurring in the facility to ensure the resident receives the proper follow up, assessment, and carex4weeks then monthly x2. The results of this audit will be presented to the QAPI committee monthly to determine effectiveness of plan of correction.
5. Facility will be in compliance by 10/8/23.

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F 745	Continued From page 55 a male resident touches a female resident's breast, the resident should be monitored for depression or any signs of decline. OSM #3 stated that from her perspective, she would refer the female resident to a licensed clinical social worker or send the resident out for counseling. OSM #3 stated an incident such as this is a lot for someone to process and staff, "Can't not address an issue." On 8/24/23 at 2:31 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not have a policy for medically related social services or a policy for what should be done for a resident who is inappropriately touched by another resident. The social services director job description documented, "Summary: Identify and provide for each resident's social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility..."	F 745		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		10/8/23

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F 756	Continued From page 56 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a Medication Regimen Review (MRR) policy that included required time frames for pharmacist's review and physician's response to the pharmacist's recommendations, potentially affecting all residents but specifically for five of 33 residents in the survey sample; Residents #15,	F 756	1. Immediately, resident #15, #69, #16, #67, and #39 medication regimens were reviewed by the medical director and adjusted based on the recommendations. The facility and corporate team reviewed and revised the medication regimen review policy to include specific time frames for the steps in the review process and presented to the survey team on	

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F 756	Continued From page 57 #69, #16, #67 and #39. The findings include: 1. For Resident #15 the facility staff failed to ensure the medication regimen review policy contained required time frames for pharmacist's review and physician's response. Resident #15 was admitted to the facility on 1/27/22. A review of the clinical record revealed all required monthly medication regimen reviews and no concerns were identified. However, a review of the facility's monthly medication regimen review policy, dated 12/1/22, failed to reveal time frames for pharmacist's review and physician's response. On 8/23/23 at 10:38 AM an interview was conducted with ASM #2 (Administrative Staff Member), the Director of Nursing. When asked about the policy not containing time frames for the physician to act upon pharmacy recommendations, ASM #2 stated, our [MRR] policy does not include timeframes for response. It just states in a timely manner. Our expectation and what we review with our physicians is a 7-day turnover. Nursing gives the recommendations to the physicians and tell them when it needs to be done. On 8/24/23 at 2:30 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional director of operations, were made aware of the findings. No further information was provided by the end of	F 756	8/23/23. 2. Medication regimen reviews in the last 30 days were reviewed by the DON, there were no other outstanding reviews needing attention for the month of July. 3. The DON educated the nurse management team and physician□s assistants on the revised medication regimen review policy on 8/23/23. Nursing management will receive education. 4. The DON/designee will conduct an audit of the medication regimen reviews process to ensure that the provided time frames are met with the addressed reviews monthly x3. The results of this audit will be presented to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23	

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the survey.

2. For Resident #69, the facility staff failed to ensure the medication regimen review policy contained required time frames for pharmacist's review and physician's response

Resident #69 was admitted to the facility on 7/28/21.

A review of the clinical record revealed all required monthly medication regimen reviews and no concerns were identified. However, a review of the facility's monthly medication regimen review policy, dated 12/1/22, failed to reveal time frames for pharmacist's review and physician's response.

On 8/23/23 at 10:38 AM an interview was conducted with ASM #2 (Administrative Staff Member), the Director of Nursing. When asked about the policy not containing time frames for the physician to act upon pharmacy recommendations, ASM #2 stated, our [MRR] policy does not include timeframes for response. It just states in a timely manner. Our expectation and what we review with our physicians is a 7-day turnover. Nursing gives the recommendations to the physicians and tell them when it needs to be done.

On 8/24/23 at 2:30 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional director of operations, were made aware of the findings.

No further information was provided by the end of the survey.

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3. For Resident #16, the facility staff failed to ensure the Medication Regimen Review policy contained specified time frames for the physician to respond to pharmacy recommendations.

A review of the clinical record for Resident #16 revealed all required monthly medication regimen reviews and no concerns were identified. However, a review of the facility policy, "Medication Regimen Review" failed to specify specific time frames for the physician to respond to any pharmacy recommendations.

On 8/23/23 at 10:38 AM, an interview was conducted with ASM #2, (Administrative Staff Member) the Director of Nursing. She stated that the facility's policy did not include timeframe for physician's response to pharmacy recommendations. She stated that the policy "just says in a timely manner." She stated that it was the facility's expectation and what they review with the physicians is a seven day turnover. She stated that they give the pharmacy recommendation to the physicians and tell them when it needs to be done.

On 8/24/23 at 2:28 PM, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

4. For Resident #67, the facility staff failed to ensure the Medication Regimen Review policy contained specified time frames for the physician to respond to pharmacy recommendations.

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A review of the clinical record for Resident #67 revealed all required monthly medication regimen reviews and no concerns were identified. However, a review of the facility policy, "Medication Regimen Review" failed to specify specific time frames for the physician to respond to any pharmacy recommendations.

On 8/23/23 at 10:38 AM, an interview was conducted with ASM #2, (Administrative Staff Member) the Director of Nursing. She stated that the facility's policy did not include timeframe for physician's response to pharmacy recommendations. She stated that the policy "just says in a timely manner." She stated that it was the facility's expectation and what they review with the physicians is a seven day turnover. She stated that they give the pharmacy recommendation to the physicians and tell them when it needs to be done.

On 8/24/23 at 2:28 PM, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

5. For Resident #39 (R39), the facility staff failed to develop and maintain a comprehensive MRR (medication regimen review) policy to include time frames for the steps in the process of the medication regimen review procedure.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/9/2023, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating the resident was

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moderately impaired for making daily decisions. The assessment documented R39 receiving an antidepressant seven of the seven days during the assessment period and an antianxiety medication seven of seven days during the assessment period.

R39 was selected for unnecessary medication review during the survey dates.

On 8/22/2023 at 12:51 p.m., during entrance conference with ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing, a request was made for the facility medication regimen review policy.

Review of the provided policy failed to evidence time expectations for physician and facility response to pharmacy recommendations.

On 8/23/2023 at 10:38 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the facilities current medication regimen review policy did not include a time frame for physician response. She stated that it only said "in a timely manner." She stated that their expectation and what they reviewed with the physicians was in a 7 day turnover. She stated that they gave the pharmacy reviews to the physicians and told them when they needed to be done.

On 8/24/2023 at 2:27 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional director of operations were made aware of the above concern.

No further information was presented prior to exit.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		10/8/23

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F 758	Continued From page 63 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to evidence monitoring of psychotropic medication for one of 33 residents in the survey sample, Resident #39. The findings include: For Resident #39 (R39), the facility staff failed to monitor behaviors and for adverse effects of an antianxiety and antidepressant medication. R39 was admitted to the facility with diagnoses that included but were not limited to bipolar disorder, major depressive disorder and alcohol dependence with alcohol-induced persisting dementia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/9/2023, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. The assessment documented R39 receiving an antidepressant seven of the seven days during the assessment period and an antianxiety medication seven of seven days during the	F 758	1. Behavior monitoring orders were immediately placed for resident #39 for antianxiety and antidepressant medication regimens. 2. On 8/25/23 the DON/designee initiated a 100% review of residents receiving psychotropic medications for behavior monitoring orders, orders placed for any discrepancies noted. 3. On 8/24/23 education for nurses was initiated by the DON/designee on the Use of Psychotropic Drugs regarding the importance of placing behavior monitoring orders for residents receiving psychotropic medications. Nurses will receive education. 4. The DON/designee will review the daily order listing report Monday through Friday for any newly prescribed psychotropic medications to ensure a behavior monitoring order is in place for 4 weeks then monthly x2. The results of this audit will be submitted to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	

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assessment period.

The physician orders for R39 documented in part, "Buspirone HCl (1) Tablet 10 MG (milligram) Give 1 tablet by mouth three times a day for depression. Order Date: 07/25/2023... Amitriptyline HCl (2) Tablet 150 MG Give 1 tablet by mouth at bedtime for depression. Order Date: 07/25/2023... Escitalopram Oxalate (3) Tablet 20 MG Give 1 tablet by mouth one time a day for Depression. Order Date: 07/25/2023..."

The eMAR (electronic medication administration record) for R39 dated 7/1/2023-7/31/2023 and 8/1/2023-8/31/2023 failed to evidence psychotropic medication monitoring for R39. The eMAR documented the medications above administered each day as ordered.

The comprehensive care plan for R39 documented in part, "(Name of R39) has use of psychotropic medications r/t (related to) antidepressant, anxiety. Date Initiated: 01/23/2020. Revision on: 02/20/2020." Under "Interventions" it documented in part, "... Monitor for adverse effects daily. Notify MD (medical doctor) prn (as needed) and document. Date Initiated: 01/23/2020." The care plan further documented "The resident uses antidepressant medication (SPECIFY medications) r/t Depression. Date Initiated: 10/28/2022. Revision on: 04/21/2023." Under "Interventions" it documented in part, "Administer Antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness Q-Shift (every shift). Date Initiated: 10/28/2022. Revision on: 04/21/2023..." The care plan also documented, "The resident uses anti-anxiety medication r/t Anxiety disorder. Date Initiated:

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10/29/2022. Revision on: 04/21/2023." Under "Interventions" it documented in part, "Administer Anti-Anxiety medications as ordered by physician. Monitor for side effects and effectiveness Q-Shift. Date Initiated: 10/29/2022. Revision on: 04/21/2023..."

The clinical record failed to evidence monitoring for adverse effects and side effects of psychotropic medications each shift as documented in the plan of care.

On 8/23/2023 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that there was a prompt on the eMAR where they documented behavior and side effect monitoring of psychotropic medications. She stated that monitoring was done every shift and documented on the eMAR. She reviewed R39's eMAR and stated that she did not see the behavior monitoring and side effect monitoring on the eMAR.

On 8/23/2023 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the executive director for evidence of behavior and side effect monitoring for R39.

On 8/24/2023 at 10:03 a.m., ASM #2, the director of nursing stated that they did not have any behavior or side effect monitoring to provide for R39 and they had placed an order to start documenting the monitoring now.

The facility policy "Use of Psychotropic Drugs" revised 12/1/2022 documented in part, "Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented

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in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s)... 9. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial wellbeing will be evaluated on an ongoing basis, such as: a. Upon physician evaluation (routine and as needed), b. During the pharmacist's monthly medication regimen review, c. During MDS review (quarterly, annually, significant change), and d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care. 10. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record..."

On 8/24/2023 at 2:27 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional director of operations were made aware of the above concern.

No further information was presented prior to exit.

Reference:
(1) Buspirone is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety. Buspirone is in a class of medications called anxiolytics. It works by changing the amounts of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html

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F 758	Continued From page 67 (2) Amitriptyline is used to treat symptoms of depression. Amitriptyline is in a class of medications called tricyclic antidepressants. It works by increasing the amounts of certain natural substances in the brain that are needed to maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682388.html (3) Escitalopram is used to treat depression in adults and children and teenagers 12 years of ago or older. Escitalopram is also used to treat generalized anxiety disorder (GAD; excessive worry and tension that disrupts daily life and lasts for 6 months or longer) in adults, teenagers, and children 7 years of age and older. Escitalopram is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603005.html	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		10/8/23

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F 761	Continued From page 68 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to securely store a medication for one of 33 residents in the survey sample, Resident #52. The findings include: For Resident #52 (R52), the facility staff failed to store the resident's Midodrine (1) in a secure manner. On 8/24/23 at 8:35 a.m., the surveyor retrieved R52's dialysis communication notebook from an open shelf behind the nurses' desk. In the front of the notebook, a medication card containing 16 tablets of Midodrine was clipped inside the notebook by way of a three whole punch and three ring prongs. On 8/24/23 at 11:30 a.m., LPN (licensed practical	F 761	1. The Midodrine bubble pack was immediately removed from resident #52 dialysis binder and stored in the appropriate place. 2. On 8/24/23 dialysis books were observed by the unit manager without any deficiencies noted. 3. On 8/24/23 the unit manager spoke to Davita Dialysis center via telephone to communicate storing medications in a resident□s binder was not secure and should be transferred through the medical team only. The dialysis team understood. 4. The DON/designee will monitor the dialysis books weekly to ensure no medications are being stored in the binders weekly x4 weeks and then monthly x1. The results of this audit will be presented to the QAPI committee monthly to determine effectiveness of plan of correction.	

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F 761	Continued From page 69 nurse) #7 was interviewed. She stated that all medications should be locked inside the medication cart, or stored in the locked medication refrigerator in the medication room. She stated: "We have to keep them locked up for resident safety. When shown R52's dialysis notebook with the Midodrine medication card clipped inside the notebook, LPN #7 shook her head and stated: "Well that is inappropriate." She acknowledged the medication was unsecured. On 8/24/23 at 2:28 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were informed of these concerns. A review of the facility policy, "Medication Storage," revealed, in part: "It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms...to ensure proper...security...All drugs and biologicals will be stored in locked compartments...Only authorized personnel will have access to the keys in locked compartments." No further information was provided prior to exit. NOTES (1) "Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure." This information is taken from the website https://medlineplus.gov/druginfo/meds/a616030.html#:~:text=Midodrine%20is%20used%20to%20tr	F 761	5. Facility will be in compliance by 10/8/23.	

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F 761	Continued From page 70 eat,tighten%2C%20which%20increases%20bloo d%20pressure.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. 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 provide food in a palatable and appetizing manner from one of one facility kitchens. The findings include: On 8/23/23 at 12:00 PM, observation of the tray line service began. Food temperatures were obtained by OSM #9 (Other Staff Member) a cook, with a facility thermometer, as follows: Mashed potatoes was 185 degrees Puree carrots was 175 degrees Puree bread was 180 degrees Puree barbeque chicken was 178 degrees Minced chicken was 180 degrees Gravy was 190 degrees Tomato soup was 175 degrees Chicken without barbeque sauce was 175 degrees Rice was 160 degrees	F 804	1. No residents were identified therefore no immediate correction occurred. 2. Residents have the potential to be affected when the facility does not provide food in a palatable and appetizing manner. 3. On 8/24/23 the administrator educated the dietary director on the Food Preparation Guidelines regarding providing palatable and appetizing meals. The dietary manager and administrator are collaborating with the corporate team to make changes to the dietary department to ensure residents receive food in a palatable and appetizing manner. This includes but is not limited to ordering new thermal plate casings, ordering and cooking with different spices and ingredients, and re-interviewing residents to obtain their food preferences. 4. The dietary manager will conduct food temperature audits 3x a week for 4 weeks	10/8/23

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F 804	Continued From page 71 Carrots was 180 degrees Baked beans was 178 degrees Barbeque chicken was 172 degrees On 8/23/23 at 1:05 PM, OSM #8, the dietary manager, was notified that a test tray was being requested. The test tray was prepared and the cart the test tray was on was then taken to the upstairs unit. At 1:20 PM, OSM #8 obtained the temperatures on the test tray with a facility thermometer as follows: Mashed potatoes was 120 degrees Puree carrots was 118 degrees Puree bread was 115 degrees Puree barbeque chicken was 115 degrees Carrots was 115 degrees Baked beans was 118 degrees Barbeque chicken was 120 degrees. Two surveyors and OSM #8 all taste tested the food. There was agreement that the food was not warm enough for meal enjoyment. The regular carrots had an odd vinegar-like flavor. The puree carrots had the same flavor but stronger and was off-putting. The baked beans were lacking flavor. The chicken was fair on flavor but was not hot. The puree bread tasted like thickener and was disliked by all. The facility policy, "Food Preparation Guidelines" was reviewed. This policy documented, "...Food shall be prepared by methods that conserve nutritive value, flavor and appearance...Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature..." On 8/23/23 at 4:01 PM, at the end-of-day meeting, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2, the Director of	F 804	and then monthly x2 of food being served. The dietary manager will conduct 10 random resident interviews a week for 4 weeks, and then 2x a month for 3 months to receive feedback on the resident□s evaluation of meals□ tastes and temperatures. The results of these audits and interviews will be presented to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	

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F 804	Continued From page 72 Nursing, were made aware of the findings. ASM #1 stated that the facility switched from an outsourced dietary service company to in-house dietary department staff and have already been working on some of the things identified.	F 804		
F 812 SS=E	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. §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 that the facility staff failed to store, prepare and serve food in a sanitary manner in one of one facility kitchens. The findings include: On 8/22/23 at approximately 12:15 PM, the	F 812	1. On 8/23/23 the black substance on the floor and wall, the dust on air vent, and the wire rack were cleaned by the dietary, housekeeping, and maintenance staff. On 8/23/23 OSM #8 immediately put on a beard guard. On 8/23/23 OSM #9 was educated on the Sanitary Inspection policy regarding infection control practices in the kitchen.	10/8/23

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	495086	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY POINTE REHABILITATION AND NURSING	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

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F 812	Continued From page 73 kitchen inspection was conducted with OSM #8 (Other Staff Member) the dietary manager. A thick wet black substance noted on the floor along wall behind ice machine. This substance was noted to be a strip of approximately 6 inches wide, starting at the wall and out into the floor for approximately 6 inches, and ran along the edge of the floor / wall behind the ice machine. An air vent on the wall next to meat slicer was heavily caked with brown dust and lint substance. The wire racks on which dishware was stored was noted to have a tacky residue all over them. On 8/23/23 during tray line observation, at 12:05 PM, OSM #9, a cook, was obtaining temperatures of the food on the steam table. As she reached over one steam table tray of food to obtain the temperature of an item on the back row, her apron was noted to come in contact with the serving end of serving scoops that were on the steam table to be used during meal service. OSM #8 had facial hair and was not wearing a beard guard the entire time. He was noted to be plating and wrapping the desserts that were served for this lunch meal. At one point, he was assisting another kitchen staff member with lifting a stack of trays. His uncovered chin was noted to be hovering approximately one inch above the surface of the top tray. This tray was the next tray used during this meal service. On 8/23/23 at 3:12 PM, an interview was conducted with OSM #8. He stated that the dish racks, vent, and floor behind the ice machine should not be in the condition they were identified in. He stated that he has been with the facility about a week and did not know when the facility last did a deep clean of the kitchen and that he would be scheduling a deep clean. When asked	F 812	2. Residents have the potential to be affected when the facility fails to store, prepare, and serve food in a sanitary manner, 3. On 8/23/23 education for dietary staff was initiated by the SDC on the Sanitary Inspection policy. Dietary staff will receive education. The dietary manager and housekeeping director created a deep clean schedule and checklist to ensure the entire kitchen meets the policies expectations. 4. The Administrator/designee will conduct audits of proper cover usage in the kitchen, conduct cleanliness rounds, and observe temperatures being taken by the cook throughout the week x4weeks then monthlyx1.The administrator/ designee will audit the appropriate use of beard guards 3x a week for 4 weeks and 1x week for 2 months. The dietary manager will observe sanitary practices during meal preparation and plating of the meal 2x a week for a month and 1x a month for 2 months. The results of these audits will be presented to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	

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F 812	Continued From page 74 about the beard guard, he stated, "I will put one on." The facility policy, "Sanitation Inspection" was reviewed. This policy documented, "It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations....All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects..." On 8/23/23 at 4:01 PM, at the end-of-day meeting, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2, the Director of Nursing, were made aware of the findings. ASM #1 stated that the facility switched from an outsourced dietary service company to in-house dietary department staff and have already been working on some of the things identified.	F 812		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside	F 840		10/8/23

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F 840	Continued From page 75 resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain a current dialysis contract for two of 33 residents in the survey sample, Residents #52 and #22. The findings include: 1. For Resident #52 (R52) the facility staff failed to evidence a current dialysis contract. A review of R52's clinical record revealed the following order, dated 2/3/23: "Outpatient Hemodialysis...Outside Center...Days Scheduled: Monday, Wednesday, Friday chair time 7:30am." A review of R52's MARs (medication administration records) from February through August 2023 revealed the resident had been receiving dialysis services as ordered. At the entrance conference on 8/22/23 at 12:25 p.m., ASM (administrative staff member) #1, the executive director, was asked to provide current contracts for the current companies from which residents were receiving dialysis services. On 8/24/23 at 2:28 p.m., ASM (administrative staff member) #1, the executive director was asked again to provide evidence of current dialysis contracts. She stated she could not	F 840	1. Administrator followed up on securing dialysis contracts for resident #52 and resident #22 2. Residents who receive dialysis services are at risk when the facility does not have a signed contract with a dialysis company. 3. On 8/24/23 the regional director of operations educated the Administrator on the regulation of maintaining a current dialysis contract. The facility and the dialysis company are currently in the review process of a dialysis contract and will be signed as soon as possible. 4.Administrator will audit dialysis contracts and dialysis patients monthly for 3 months to ensure there is an up-to-date dialysis contracts The results of these audits will be presented to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23	

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F 840	Continued From page 76	F 840		

provide a current dialysis contract at that time.

No further information was provided prior to exit.

2. For Resident #22, the facility failed to evidence a written dialysis agreement with one dialysis center.

Resident #22 was admitted to the facility on 3/11/22 with diagnosis that included but were not limited to: ESRD (end stage renal disease), and dialysis.

A review of the comprehensive care plan dated 3/21.22, which revealed, "FOCUS: The resident needs dialysis type hemo/peritoneal related to renal failure. The resident is at nutrition and/or hydration risk due to diagnosis of ESRD. INTERVENTIONS: HD (hemodialysis) every Monday-Wednesday-Friday..."

During the entrance conference to the facility on 8/22/23, a request was made for the dialysis contracts/agreements to be provided.

On 8/24/23 at approximately 8:45 AM, ASM (administrative staff member) #1, the executive director stated,
"We have a contract but not a current copy. The dialysis company keeps sending us to legal. Someone before me signed the contract, the executive director or the director of regional operations signed the contract. We have been trying to get a copy of the contract since you all came in."

On 8/24/23 at 2:30 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional

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F 840	Continued From page 77 director of operations, were made aware of the findings. ASM #1 stated, we should have a dialysis contract. No further information was provided prior to exit.	F 840		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		10/8/23

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F 842	Continued From page 78 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of 33 residents in the survey	F 842	1. Resident #7 medical record was reviewed and revised as needed. There was no adverse outcome from the deficient practice.	

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F 842	Continued From page 79 sample, Resident #7. The findings include: For Resident #7 (R7), the facility staff failed to document an incident where a male resident touched the resident's breast on 7/12/22. A facility synopsis of events documented that on 7/12/22, an employee witnessed a male resident touching himself and fondling R7's breast. A review of R7's clinical record failed to reveal documentation regarding the 7/12/22 event. On 8/24/23 at 8:55 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated a progress note should definitely be made in the clinical record if a male resident touches a female resident's breast. LPN #2 stated this should be documented in both residents' clinical records. On 8/24/23 at 2:31 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Documentation in Medical Record" documented, "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation."	F 842	2. There are no current residents that were involved in the incident that require their medical record be revised. 3. On 8/24/23 the DON/designee initiated education for nurses on the Documentation in Medical Record policy regarding the importance of keeping an accurate medical record and recording residents incidents in the medical record. 4. The DON/designee will conduct a weekly audit of any risk incidents to ensure there is accurate documentation of the event weekly x4 then monthly x2. The results of these audits will be presented to the QAPI committee monthly to determine effectiveness of plan of correction. 5. Facility will be in compliance by 10/8/23.	