STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEDALE HEALTH & REHABILITATION	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/19/2023 through 9/21/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. The census in this 128 certified bed facility was 106 at the time of the survey. The survey sample consisted of 35 current resident reviews and five closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/19/23 through 9/21/23. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00059236-substantiated with deficiency). The Life Safety Code survey/report will follow. The census in this 128 certified bed facility was 106 at the time of the survey. The survey sample consisted of 35 current resident reviews and five closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe	F 557		11/3/23

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

Electronically Signed | 10/16/2023

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F 557	Continued From page 1 upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure residents dignity for one of 40 residents in the survey sample, Resident #120. The findings include: The facility staff failed to ensure a resident's dignity for Resident #120 as his urinary catheter bag had no privacy covering during observations on 9/19/23 at 1:45 PM, 9/20/23 8:10 AM and 9/20/23 at 4:15 PM. Resident #120 was admitted to the facility on 9/12/23 with diagnoses that included but were not limited to, BPH (benign prostatic hypertrophy). A review of the baseline care plan dated 9/14/23, which revealed, "FOCUS: The resident has Indwelling Catheter: history of BPH. INTERVENTIONS: The resident has 16 FR/10cc Position catheter bag and tubing below the level of the bladder and away from entrance room door. Dignity bag to cover drainage bag content. On 9/19/23 at 1:45 PM, 9/20/23 8:10 AM and 9/20/23 at 4:15 PM, Resident #120 was observed in their room and the uncovered urinary drainage bag, which contained urine in it, was visible from doorway. On 9/20/23 at 8:10 AM an interview was	F 557	This plan of correction is respectfully submitted and is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #120 has had their urinary catheter bag covered to ensure residents dignity. 2. An audit has been performed on all residents who have a urinary catheter bag. Any residents found to not have their urinary catheter bag covered has been corrected. 3. The Director of Nursing/Designee will reeducate CNAs, LPNs, and RNs on the importance of ensuring urinary catheter bags are covered to maintain residents' dignity. This education will include, but not be limited to, how to cover a urinary catheter bag and how to help the resident to keep their urinary catheter bag covered. 4. The Director of Nursing/Designee will perform an audit to ensure all residents who have urinary catheter bag has a privacy covering weekly for 4 weeks and then monthly for 2 months. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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F 557	Continued From page 2 conducted with RN (registered nurse) #2. When asked if a urinary catheter bag has no privacy covering, is the resident's dignity being maintained, RN #2 stated, no, it is not. On 9/21/23 at 9:15 AM an interview was conducted with LPN (licensed practical nurse) #3. Asked if a resident's dignity is maintained if their urinary bag has no privacy covering, LPN #3 state, no, their dignity is not maintained. On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings. A review of the facility's "Dignity" policy revealed, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents; for example: helping the resident to keep urinary catheter bags covered." No further information was provided prior to exit.	F 557	5. The date of compliance is: 11/3/23	
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		11/3/23

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physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 4	F 580		

room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to notify the physician of a significant change in condition and/or a need to alter treatment in a timely manner for two of 40 residents in the survey sample, Residents #106 and #96.

The findings include:

1. For Resident #106 (R106), the facility staff failed to notify the physician of a pressure injuries in a timely manner.

A physical therapy evaluation dated 5/19/23 documented R106 presented with unstageable bilateral heel pressure areas (injuries) (1). Further review of R106's clinical record failed to reveal the physician was notified of the pressure injuries until 6/2/23. A physician note dated 6/2/23 documented, "SKIN: (Name) indicated that patient has dark area on both heels. Wound care team to follow. Warm and dry. No induration, nodules, or discoloration..."

On 9/20/23 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated nurses should notify the physician and obtain treatment orders when a resident is admitted with pressure injuries and when a resident develops pressure injuries.

On 9/21/23 at 11:28 a.m., an interview was conducted with OSM (other staff member) #7 (R106's physical therapist). OSM #7 stated he reported R106's pressure injuries to the nursing

This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements.

1. Residents #106 and #96 no longer reside at the facility.

2. An audit has been performed on all residents who have a pressure injury to ensure timely notification to the physician was completed. A MAR to Cart audit has been completed for all current medication carts. Any physician notifications for resident pressure injuries and medications not available have now been made and are documented.

3. The Director of Nursing/Designee will reeducate LPNs, and RNs on the importance of notifying the physician of a significant change in condition and/or need to alter treatment in a timely manner. This education will include, but not limited to notifying the physician of a pressure injury in a timely manner and notifying the physician if 3 consecutive doses of a vital medication are not available.

4. The Director of Nursing/Designee will perform an audit on 25% of residents weekly for 4 weeks and then monthly for 2 months to ensure timely notification of

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F 580	Continued From page 5 staff on 5/19/23. On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Pressure Injury Prevention And Management" documented, "3. Observations of new pressure ulcer/injury will be: a. Reported to the physician/practitioner for further evaluation and treatment." Reference: (1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear... Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue)..." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf 2. For Resident #96 (R96), the facility staff failed to notify the physician when the medication Nubeqa (1) was not available for administration on multiple dates in August 2023. A review of R96's clinical record revealed a physician's order dated 8/24/23 for Nubeqa 300 mg (milligrams)- two tablets by mouth two times a	F 580	resident pressure injuries and resident medications that are not available for administration. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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day for prostate cancer. A review of R96's August 2023 MAR (medication administration record) revealed the same physician's order for Nubeqa. On 8/26/23 (a.m. and p.m. doses), 8/27/23 (a.m. and p.m. doses), 8/28/23 (p.m. dose), 8/29/23 (p.m. dose), 8/30/23 (p.m. dose) and 8/31/23 (a.m. dose), the the code, "9=Other / See Nurse Notes." Nurses' notes dated 8/26/23 documented, "Will administer when med arrive from pharmacy" and "Medication out of stock, resident made aware, will continue to monitor" was documented on the MAR.

Nurses' notes dated 8/27/23 had documented, "Will administer when med arrive from pharmacy" and "Awaiting delivery from pharmacy." A nurse's note dated 8/28/23 had documented, "Medication not in stock, reorder on 8/24/23." A nurse's note dated 8/29/23 had documented, "Medication reordered as currently unavailable [sic]." A nurse's note dated 8/30/23 had documented, "On order from pharmacy." A nurse's note dated 8/31/23 had documented, "Will administer when med arrive from pharmacy." Further review of nurses' notes and the August 2023 MAR failed to reveal documentation that Nubeqa was administered to R96 on the above dates, and failed to reveal the physician was notified until 9/1/23.

On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that if a medication is not available for administration, the nurses are supposed to notify the doctor and see what he recommends. LPN #3 stated this should be done each time a medication is not available, and this should be documented in the clinical record.

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F 580	Continued From page 7 On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "General Guidelines for Medication Administration" documented, "If 3 consecutive doses, or in accordance with facility policy, of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response." Reference: (1) "Darolutamide (Nubeqa) is used to treat certain types of prostate cancer...Do not stop taking darolutamide without talking to your doctor." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a619045.html	F 580		
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	F 623		11/3/23

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(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 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

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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 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 §

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F 623	Continued From page 10 483.70(l). 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 provide evidence that written RP (responsible party) and ombudsman notification was provided when three of 40 residents in the survey sample were transferred to the hospital, Residents #49, Resident #33, and Resident #11. The findings include: 1. The facility staff failed to evidence provision of required written notification was provided to the RP (responsible party) and ombudsman at the time of discharge for Resident #49. Resident #49 was transferred to the hospital on 7/19/23. Resident #49 was admitted to the facility on 5/9/23 with diagnosis that included but were not limited to: diabetes, congestive heart failure, COPD (chronic obstructive pulmonary disease) and acute respiratory failure. Resident # A review of Resident #49's eINTERACT (interventions to reduce acute care transfer) form dated 7/19/23 revealed, "COPD, shortness of breath. Sent to hospital." An interview was conducted on 9/20/23 at 2:30 PM with LPN (licensed practical nurse) #2. When asked who provides written notification to the RP and ombudsman, LPN #2 stated, "We call the family, but social services sends them something I believe. They also contact the ombudsman." An interview was conducted on 9/21/23 at 9:48	F 623	This plan of correction is respectfully submitted and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. The facility has provided written notification for hospital transfer to the Responsible Parties and Ombudsman for Residents #49, #33 and #11. 2. An audit has been performed on all residents who have been transferred to the hospital in the last 30 days to ensure written notification has been provided to the Responsible Parties and Ombudsman. Any residents found to have not had written notification sent to their Responsible Parties and Ombudsman have been completed. 3. The Administrator/Designee will reeducate Social Services Director on the importance of providing written notification to Responsible Parties and Ombudsman when residents are transferred to the hospital. 4. The Administrator/Designee will perform an audit on all residents transferred to the hospital weekly for 4 weeks and then monthly for 2 months to ensure written notification has been provided to Responsible Parties and Ombudsman of the transfer. The Administrator/Designee will identify any	

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AM with OSM (other staff member) #4, the director of social services. When asked who provides written RP and ombudsman notification, OSM #4 stated, "The complete list of discharges every month is sent to the ombudsman and she takes the list and reviews it. I keep a binder of the original list. I mail it to the resident's house or give it to the resident if they are responsible. I have not found a blank copy of the notice of discharge form that I can use. Date of transfer, where and why they were sent out and date of form are mailed out to the RP."

On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings.

A review of the facility's "Facility Initiated Transfer or Discharge" policy revealed "Before a facility transfers or discharges a resident, the facility will 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 written notice will include the following: The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; 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; The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; For nursing facility residents with intellectual and developmental disabilities or related disabilities,

issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.

5. The date of compliance is: 11/3/23

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the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities and the facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. The copy of the notice to the ombudsman will be sent at the same time notice is provided to the resident and resident representative. Copies of notices for emergency transfers will be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.

No further information was provided prior to

2. For Resident #33 (R33), the facility staff failed to provide evidence that written notification of transfer was provided to the resident and/or responsible party, or the long-term care ombudsman for a facility-initiated transfer on 7/29/2023.

A review of R33's clinical record revealed the following progress notes:
- "7/29/2023 07:52 (7:52 a.m.) N.O. (new order) received to send resident to ED (emergency department) r/t (related to) r (right) femur fx (fracture)."
- "8/2/2023 15:30 (3:30 p.m.) Note Text: Readmit to facility from Acute Care Hospital for repair and treatment of right hip fracture. Surgical procedure was performed to right hip, dressing dry and intact, no bleeding..."

Further review of the clinical record failed to reveal evidence that written notification of transfer was provided to the resident and/or responsible party or the long-term care ombudsman for the

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transfer on 7/29/2023.

On 9/20/2023 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of written notification of transfer provided to the resident and/or responsible party and the long-term care ombudsman for the transfer on 7/29/2023 for R33.

On 9/21/2023 at approximately 8:00 a.m., ASM #1 stated that they did not have any evidence of written notification of transfer provided to the resident and/or responsible party and the long-term care ombudsman for the transfer on 7/29/2023 for R33.

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the nursing staff did not provide any written notification of transfer to the resident or the responsible party when they went to the hospital. She stated that they notified the family by telephone of the transfer and was not sure who was responsible for ombudsman notification.

On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN #3. LPN #3 stated that the nursing staff made a phone call to the family when the resident was transferred to the hospital but did not send a written notification of transfer. She stated that she thought that the social worker sent the written notification of transfer and the ombudsman notification of transfer.

On 9/21/2023 at 9:48 a.m., an interview was conducted with OSM (other staff member) #4, the director of social services. OSM #4 stated that

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they were new to the facility and the process they followed was to send a list of discharges to the ombudsman by email and they had been doing this since they started at the facility. She stated that they had been unable to find some notices from the former social worker but it looked like they were sending them monthly. She stated that she had been unable to find any written notices of transfer. She stated that at their former job they kept a binder with the copies of the notice of discharge or transfer and mailed them to the home addresses but they had been unable to find an original of the notice of discharge or transfer that the facility used.

On 9/21/2023 at approximately 1:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

3. For Resident #11 (R11), the facility staff failed to provide evidence that written notification of transfer was provided to the resident and/or responsible party for facility-initiated transfers on 6/11/2023 and 6/27/2023.

A review of R11's clinical record revealed the following progress notes:
- "6/11/2023 08:50 (8:50 a.m.) Note Text: EMS (emergency medical services) arrived on site, Pt (patient) being transported to hospital, unknown which hospital atm (at this moment)."
- "6/14/2023 17:58 (5:58 p.m.) Admit Info: (R11) was admitted from Acute hospital via Stretcher for Seizures. Per Resident/Family the patient was admitted for: Seizures; Long Term Placement..."

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- "6/27/2023 16:32 (4:32 p.m.) ... At 11:10 nurse came to me stating resident having a seizure. Nurse entered the room and resident laying on left side with full body shaking. Activity lasted for 8 mins. Resident not verbally responsive after the seizure with abnormal breathing. Sats (oxygen saturation) 88% on room air. Non-rebreather added. Resident sent to ER (emergency room) for full code status. (Name of provider), Hospice, and family notified."
- "7/4/2023 19:17 (7:17 p.m.) Admit Info: (R11) was admitted from Acute hospital via Stretcher for seizures activity. Per Resident/Family the patient was admitted for Long Term Placement..."

Further review of the clinical record failed to reveal evidence that written notification of transfer was provided to the resident and/or responsible party for the transfer on 6/11/2023 and 6/27/2023.

On 9/20/2023 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence that written notification of transfer was provided to the resident and/or responsible party for the transfer on 6/11/2023 and 6/27/2023 for R11.

On 9/21/2023 at approximately 8:00 a.m., ASM #1 stated that they did not have any evidence that written notification of transfer was provided to the resident and/or responsible party for the transfer on 6/11/2023 and 6/27/2023 for R11.

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the nursing staff did not provide any written notification of transfer to the resident or the responsible party when they went to the hospital. She stated that they notified the

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F 623	Continued From page 16 family by telephone of the transfer. On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN #3. LPN #3 stated that the nursing staff made a phone call to the family when the resident was transferred to the hospital but did not send a written notification of transfer. She stated that she thought that the social worker sent the written notification of transfer. On 9/21/2023 at 9:48 a.m., an interview was conducted with OSM (other staff member) #4, the director of social services. OSM #4 stated that she had been unable to find any written notices of transfer. She stated that at their former job they kept a binder with the copies of the notice of discharge or transfer and mailed them to the home addresses but they had been unable to find an original of the notice of discharge or transfer that the facility used. On 9/21/2023 at approximately 1:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		11/3/23

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F 625	Continued From page 17 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that bed hold notification was provided to the resident and/or responsible party (RP), when three out of 40 residents in the survey sample were transferred to the hospital; Residents #49, Resident #33, and Resident #11. The findings include: 1. For Resident #49, the facility staff failed to evidence provision of bed hold notification to the resident and/or the responsible party at the time of transfer to the hospital on 7/19/23. A review of Resident #49's eINTERACT	F 625	This plan of correction is respectfully submitted and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Residents #49, #33 and #11 have all returned to the facility from the hospital. 2. An audit has been performed on all residents who are currently out of the facility at the hospital to ensure written information has been provided to the resident or resident representative about the bed-hold policy. Any residents found to have not had written information provided to them or their representative	

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F 625	Continued From page 18 (interventions to reduce acute care transfer) form dated 7/19/23 revealed, "COPD, shortness of breath. Sent to hospital." A review of the clinical record revealed there was no evidence that written bed-hold notice was provided to the resident and/or RP when Resident #49 was transferred to the hospital on 7/19/23. An interview was conducted on 9/20/23 at 2:30 PM with LPN (licensed practical nurse) #2. When asked who provides bed hold notification upon transfer, LPN #2 stated, there is a form they are to send. When asked if there is evidence of the bed hold form sent. LPN #2 stated, no, they do not keep a copy of the form. An interview was conducted on 9/21/23 at 9:48 AM with OSM (other staff member) #4, the director of social services. When asked who provides the bed hold notification, OSM #4 stated, there should be blank copies of the form at the nurse's station that are filled out with the price of the bed hold that is sent out with the resident, and then the family calls admission to reserve the bed hold. OSM #4 they did not know if nursing keeps a copy. On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings. A review of the facility's "Bed Hold" policy revealed "Prior to initiated transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Prior to a transfer, written information will be given to the residents	F 625	have been completed and documented. 3. The Director of Nursing/Designee will reeducate LPNs and RNs on the importance of providing written information to the resident or resident representative about the bed-hold policy. Administrator will provide education to Social Servies Director on bed-hold policy. The education will include but not limited to documenting that the bed-hold notification was provided. 4. The Administrator/Designee will perform an audit of all discharged residents weekly x 4 weeks and then monthly for 2 months to ensure residents or resident representatives have been provided with written information about the bed-hold policy. The Administrator/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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and the resident representatives that explains in detail: The rights and limitations of the resident regarding bed-holds; reserve bed payment policy as indicated by the state plan (Medicaid residents); The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and The details of the transfer (per the notice of transfer)."

No further information was provided prior to exit.

3. For Resident #33 (R33), the facility staff failed to provide evidence that bed-hold notice was provided to the resident and/or responsible party for a facility-initiated transfer on 7/29/2023.

A review of R33's clinical record revealed the following progress notes:
- "7/29/2023 07:52 (7:52 a.m.) N.O. (new order) received to send resident to ED (emergency department) r/t (related to) r (right) femur fx (fracture)."
- "8/2/2023 15:30 (3:30 p.m.) Note Text: Readmit to facility from Acute Care Hospital for repair and treatment of right hip fracture. Surgical procedure was performed to right hip, dressing dry and intact, no bleeding..."

Further review of the clinical record failed to reveal evidence that bed-hold notice was provided to the resident and/or responsible party for the transfer on 7/29/2023.

On 9/20/2023 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of bed-hold notice provided to the resident and/or responsible party for the transfer on 7/29/2023 for

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R33.

On 9/21/2023 at approximately 8:00 a.m., ASM #1 stated that they did not have any evidence of bed-hold notice provided to the resident and/or responsible party for the transfer on 7/29/2023 for R33.

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the nursing staff sent a bed-hold notice with the resident to the hospital upon transfer and that it should be documented in the progress notes.

On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN #3. LPN #3 stated that the nursing staff sent a bed hold notice with the resident at the time of transfer and documented it in the progress notes.

On 9/21/2023 at approximately 1:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

4. For Resident #11 (R11), the facility staff failed to provide evidence that bed-hold notice was provided to the resident and/or responsible party for facility-initiated transfers on 6/11/2023 and 6/27/2023.

A review of R11's clinical record revealed the following progress notes:
- "6/11/2023 08:50 (8:50 a.m.) Note Text: EMS (emergency medical services) arrived on site, Pt (patient) being transported to hospital, unknown

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which hospital atm (at this moment)."
- "6/14/2023 17:58 (5:58 p.m.) Admit Info: (R11) was admitted from Acute hospital via Stretcher for Seizures. Per Resident/Family the patient was admitted for: Seizures; Long Term Placement..."

- "6/27/2023 16:32 (4:32 p.m.) ... At 11:10 nurse came to me stating resident having a seizure. Nurse entered the room and resident laying on left side with full body shaking. Activity lasted for 8 mins. Resident not verbally responsive after the seizure with abnormal breathing. Sats (oxygen saturation) 88% on room air. Non-rebreather added. Resident sent to ER (emergency room) for full code status. (Name of provider), Hospice, and family notified."
- "7/4/2023 19:17 (7:17 p.m.) Admit Info: (R11) was admitted from Acute hospital via Stretcher for seizures activity. Per Resident/Family the patient was admitted for Long Term Placement..."

Further review of the clinical record failed to reveal evidence that bed-hold notice was provided to the resident and/or responsible party for the transfer on 6/11/2023 and 6/27/2023.

On 9/20/2023 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence that bed-hold notice was provided to the resident and/or responsible party for the transfer on 6/11/2023 and 6/27/2023 for R11.

On 9/21/2023 at approximately 8:00 a.m., ASM #1 stated that they did not have any evidence that bed-hold notice was provided to the resident and/or responsible party for the transfer on 6/11/2023 and 6/27/2023 for R11.

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F 625	Continued From page 22 On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the nursing staff sent a bed-hold notice with the resident to the hospital upon transfer and that it should be documented in the progress notes. On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN #3. LPN #3 stated that the nursing staff sent a bed hold notice with the resident at the time of transfer and documented it in the progress notes. On 9/21/2023 at approximately 1:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, clinical record review, staff interview and facility document review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for three of 40 residents in the survey sample, Residents #62, #33 and #49. The findings include: 1. For Resident #62 (R62), the facility staff failed	F 641	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. MDS assessment for Resident #62 has been modified to reflect current tobacco use. MDS assessment for Resident #33 has been modified to reflect their mental status. MDS assessment for Resident #49	11/3/23

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F 641	Continued From page 23 to code the annual MDS assessment for current tobacco use. On the most recent MDS assessment, an annual assessment, with an ARD (assessment reference date) of 6/20/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. Section J documented no current tobacco use. On 9/19/2023 at 3:56 p.m., an interview was conducted with R62. R62 stated that they had smoked for years and had been smoking at the facility since admission. R62 stated that the facility stored their cigarettes and lighter in a box that they took at during the smoking times. The comprehensive care plan for R62 documented in part, "History of smoking and current smoker Date Initiated: 12/06/2019. Revision on: 08/09/2023." The "Smoking-Resident Safety Evaluation" for R62 dated 2/9/2023 documented in part, "...Tobacco Utilization: 1. Does the resident use tobacco products? Yes. Does the facility allow smoking? Yes. Tobacco products utilized: Cigarettes/Cigars..." On 9/20/2023 at 2:34 p.m., an interview was conducted with RN (registered nurse) #5, MDS coordinator. RN #5 stated that when completing the tobacco use section on the MDS assessment they reviewed the care plan and clinical record to see if the resident smoked. She reviewed R62's care plan and stated that there was a care plan for smoking and stated that she was not sure why	F 641	has been modified to reflect their use of oxygen. 2. An audit has been performed on all current resident□s MDS assessments to ensure residents current tobacco use, mental status and use of oxygen has been reflected correctly. Any resident□s assessment information found to have not accurately reflected the resident□s status has been modified. 3. The Regional Revenue Integrity Specialist/Designee will reeducate MDS Coordinators and IDT team on the importance of completing accurate assessments to reflect the resident□s status. This education will include, but not be limited to, coding current tobacco use, assessing the mental status of residents, and use of oxygen. 4. The Director of Nursing/Designee will perform an audit of 25% of resident assessments weekly x 4 weeks and then monthly for 2 months to ensure assessments accurately reflect the resident□s status. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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it was not coded for tobacco use.

According to the RAI (resident assessment instrument) Manual, Version 1.16, dated October 2018, section J1300 documented in the steps for assessment, "1. Ask the resident if he or she used tobacco in any form during the 7-day look-back period. 2. If the resident states that he or she used tobacco in some form during the 7-day look-back period, code 1, yes..."

On 9/20/2023 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

2. For Resident #33 (R33), the facility staff failed to assess the mental status on the MDS (minimum data set) assessment.

On the most recent MDS, a significant change assessment with an ARD (assessment reference date) of 8/10/2023, R33 was coded in Section B - Hearing, Speech and Vision as usually understanding others and being understood. In Section C - Cognitive Patterns, the resident interview was not completed. The resident and/or staff assessment were blank.

The nursing admission assessment dated 8/2/2023 documented R33 not having dementia or other cognitive deficits that make them unable to answer questions.

On 9/20/2023 at 2:34 p.m., an interview was conducted with RN (registered nurse) #5, MDS

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coordinator. RN #5 stated that Section C of the MDS was normally completed by the social worker but they had completed at times when the social worker position was not filled. She stated that she interviewed the resident and attempted to complete the assessment on all residents. She stated that if she was unable to complete the assessment on the resident then the staff assessment was completed. She reviewed R33's significant change assessment with the ARD of 8/10/2023 and stated that the social worker would have been responsible for completing it and that it looked like it was not done.

On 9/21/2023 at 9:48 a.m., an interview was conducted with OSM (other staff member) #4, the director of social services. OSM #4 stated that they were responsible for completing Section C of the MDS assessment. She stated that when it was due, she typically printed out a paper copy and completed it with the resident and then transferred it to the MDS. She stated that if the resident was able to speak or understand they did the resident assessment and if not they did the staff assessment so one or the other should be completed for everyone. She reviewed R33's significant change MDS with the ARD of 8/10/2023 and stated that they had started working at the facility that week and it may not have been them completing assessments that week but it should have been completed.

According to the RAI (resident assessment instrument) Manual, Version 1.16, dated October 2018, section C0100 documented in Coding Tips, "Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent

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F 641	Continued From page 26 upon item B0700, Makes Self Understood..." On 9/20/2023 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit. 3. For Resident #49, the facility staff failed to complete an accurate MDS (minimum data set), a quarterly assessment for the use of oxygen. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/8/23, 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. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, transfers and locomotion. A review of Section O: special procedures/treatments: coded the resident as oxygen- No. A review of the comprehensive care plan dated 5/9/23, which revealed, "FOCUS: The resident has altered respiratory status/difficulty breathing and COPD. INTERVENTIONS: OXYGEN SETTINGS: Bi-pap at night- FIO2 30 %." A review of the physician orders dated 6/13/23 revealed, "Bi-pap at night- FIO2 30% every evening and night shift for sob (shortness of breath). Bi-pap keep covered when not in use, every day shift."	F 641		

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F 641	Continued From page 27 On 9/21/23 at 11:20 AM, an interview was conducted with RN (registered nurse) #5, the MDS coordinator. Asked to review Resident #49's MDS Section O dated 8/8/23 and the orders for bi-pap, RN #5 stated, "Yes, this is coded incorrectly, I will modify this. We use the RAI (resident assessment instrument) as our standard." On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings. According to the RAI (resident assessment instrument) MDS Section O: 0100C, Oxygen therapy: "Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula." No further information was provided prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		11/3/23

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that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review and facility document

This plan of correction is respectfully submitted, and it is an affirmation that

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review, it was determined the facility staff failed to develop and/or implement a baseline care plan for three of 40 residents in the survey sample, Residents #119, #120 and #96.

1. For Resident #119, the facility failed to implement the baseline care plan for pre and post dialysis weights.

Resident #119 was admitted to the facility on 9/9/23 with diagnosis that included but were not limited to: ESRD (end stage renal disease) and dialysis.

A review of the baseline care plan dated 9/9/23 revealed, "FOCUS: The resident has ESRD and receives Hemodialysis on Tuesday/Thursday/Saturday (T-TH-SA). INTERVENTIONS: Pre-Post dialysis weights. Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols."

A review of the physician's order dated 9/12/23 revealed, "Dialysis every T-TH-SA. Obtain pre-dialysis vital signs, and weight - input weight from dialysis communication forms every evening shift every Tue, Thu, Sat. Obtain post-dialysis vital signs, and weight - input weight from dialysis communication forms every evening shift every Tue, Thu, Sat."

A review of Resident #119's TAR (treatment administration record) for September 2023 revealed, pre-dialysis weights were not obtained on 9/19/23 and post-dialysis weights were not obtained on 9/12/23, 9/14/23 and 9/16/23.

An interview was conducted on 9/20/23 at 8:40

corrections to the areas cited have¿been made and the facility is in compliance with participation requirements.

1. Residents #119 and #96 are no longer residing at the facility. Resident #120 has had their urinary catheter bag covered and a care plan has been developed for the use of the anticoagulant medication, Warfarin.

2. Rosedale has identified that all new residents are at risk from this deficient practice. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified.¿

3. The Director of Nursing/Designee will reeducate LPNs, and RNs on the importance of completing an admission assessment on each new admission which initiates the baseline care plan.

4. The Director of Nursing/designee will audit the baseline care plans of any new admissions 5x per week for 4 weeks and monthly for 2 months to ensure that a baseline care plan has been developed and interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident baseline care plans. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the

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F 655	Continued From page 30 AM with Resident #119, and when asked if he was weighed before and after dialysis, Resident #119 stated, no, not always. An interview was conducted on 9/20/23 at 8:00 AM with RN #2. When asked the purpose of the dialysis communication form, RN #2 stated, the purpose is to share and receive information with the dialysis center, including vital signs, weights, medications and any lab results. When asked to review Resident #119's TAR for pre and post dialysis weights, RN #2 stated the weights were not there and the the care plan was not implemented. On 9/20/23 at 3:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the findings. A review of the facility's "Care Planning-Person Centered" revealed, "A baseline care plan to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. "Baseline Care Plan": is a care plan developed within 48 hours of admission to include minimum healthcare information necessary to properly care for a resident including, but not limited to: Initial goals based on admission orders. Physician orders." No further information was provided prior to exit. 2. For Resident #120, the facility failed to implement the baseline care plan for the use of a dignity bag (cover) for an indwelling urinary catheter, and failed to develop a baseline care	F 655	Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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plan for the use of the anticoagulant medication, Warfarin.

Observations of Resident #120's urinary catheter bag revealed there was no privacy covering on 9/19/23 at 1:40 PM and 2:45 PM, 9/20/23 at 8:10 AM and 9/20/23 at 4:15 PM. The urinary catheter bag was visible from the resident's doorway.

A review of the baseline care plan dated 9/14/23 included, FOCUS: The resident has Indwelling Catheter:
history of BPH. INTERVENTIONS: The resident has 16 FR/10cc Position catheter bag and tubing below
the level of the bladder and away from entrance room door. Dignity bag to cover drainage bag content.

A review of the physician orders dated 6/13/23 included, Foley Catheter: (16 French) Balloon Size: (10 milliliters) For Diagnosis of BPH every shift.

A review of the physician orders dated 6/13/23 included, Warfarin Sodium Tablet 2.5 milligram (MG) Give 1 tablet by mouth one time a day for treating/preventing blood clots.

On 9/20/23 at 8:10 AM an interview was conducted with RN (registered nurse) #2. When asked if a urinary catheter bag has no privacy covering, is the resident's care plan implemented, RN #2 stated, "No, it is not. The privacy covering should be on the bag."

On 9/21/23 at 9:15 AM an interview was conducted with LPN (licensed practical nurse) #3. When asked if a resident's baseline care plan

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should include an anticoagulant warfarin, LPN #3 stated, yes, it should. When asked what should be included, LPN #3 stated, to assess for signs and symptoms of bleeding, labs like PT (prothrombin time) and INR (international normalized ratio) and monitoring their diet.

On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings.

No further information was provided prior to exit.

3. For Resident #96 (R96), the facility staff failed to implement the baseline care plan for pressure injury assessment, treatment, and documentation.

R96 was admitted to the facility on 8/24/23 with a diagnosis of a stage three pressure injury of the sacral region (1). R96's care plan dated 9/6/23 documented, "I have actual impairment to skin integrity r/t (related to) (Sacrum) Immobility. Administer medications, supplements and treatments as ordered...Assess/Monitor/Document wound: size, depth, margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis per facility protocols..."

A review of R96's clinical record revealed a physician's order dated 9/8/23 to cleanse the sacral wound with wound cleanser. Apply calcium alginate (used to treat wounds) to wound bed and cover with foam dressing every day shift. A review of R96's September 2023 TARs (treatment administration records) revealed the

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same physician's order but failed to reveal documentation that the treatment was completed on 9/8/23, 9/10/23, 9/11/23, 9/14/23 and 9/15/23. The spaces for nurses to sign off the treatments had been done were blank. A review of nurse's notes for all dates also failed to reveal documentation that the treatments were completed.

Further review of R96's clinical record revealed a weekly skin observation dated 9/11/23 that documented, "Open area" and "Cleanse sacral wound with wound cleanser. Apply calcium alginate to wound bed cover with foam dressing." A weekly skin observation dated 9/19/23 documented, "Admitted with open area to sacrum." The weekly skin observations failed to document a description of the pressure injury (including stage, measurements, presence or absence of any tunneling or undermining, type of tissue, or presence or absence and type of drainage) and progress in wound healing.

On 9/20/23 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that after residents are admitted, weekly skin observations should be conducted on all residents and nurses are required to look at every resident's skin. LPN #3 stated assessments of pressure injuries should include a description of the wound, the measurement of the size, any odor, the color, the presence of drainage, and the stage if the nurse is a RN (registered nurse). In regard to evidencing the completion of treatments, LPN #3 stated the nurses evidence treatments are done by signing the treatments off on the electronic treatment administration record.

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F 655	Continued From page 34 On 9/21/23 at 9:16 a.m., another interview was conducted with LPN #3. LPN #3 stated, "The purpose of the care plan is the action of the care while they [the residents] are here." In regard to care plan implementation, LPN #3 stated the nurses have access to the care plans and the mds (minimum data set) staff is available if nurses have questions about the care plan. On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Reference: (1) "Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		11/3/23

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F 656	Continued From page 35 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, facility document review and clinical record review, the facility staff failed to develop and/or implement the comprehensive care plan for eight of 40 residents in the survey sample,	F 656	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements.	

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F 656	Continued From page 36 Residents #48, #108, #52, #219, #62, #76, #11, and #16. The findings include: 1. For Resident #48 (R48), the facility staff failed to develop a comprehensive care plan for the resident's laryngectomy tube (1). R48 was admitted to the facility on 6/6/23 with a diagnosis of the presence of an artificial larynx (a laryngectomy tube). A review of R48's comprehensive care plan initiated on 6/6/23 failed to reveal documentation regarding the resident's laryngectomy tube. On 9/20/23 at 8:34 a.m., R48 was observed sitting on the bed and the resident was observed to have a laryngectomy tube. At this time, an interview was conducted with R48. The resident was unable to verbally communicate but communicated via non-verbal gestures and by writing on a communication board. R48 was asked if the nurses clean and provide care for his laryngectomy tube. The resident nodded his head side to side indicating, "No" and pointed to himself. When asked if he provides the care, R48 nodded his head up and down indicating, "Yes." When asked if the nurses check to make sure he is cleaning and caring for his laryngectomy tube, R48 nodded his head side to side, indicating, "No." On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated, "The purpose of the care plan is the action of the care while they [the residents] are here." LPN #3 stated residents' care plans should include documentation regarding a	F 656	Residents #48, #108, #52, #219, #62, #76, #11 and #16 were assessed by nursing staff and their medical records were reviewed. The residents care plans have been updated to reflect current individualized plans of care and the results of implementation are being tracked and addressed appropriately. Rosedale has identified that all residents are at risk from this deficient practice. A process has been developed and implemented in the daily interdisciplinary team meeting to identify resident care needs, ensure a care plan has been developed to meet individualized needs and the results of implementation are being tracked and addressed appropriately. The Director of Nursing/designee has in-serviced nursing leadership, interdisciplinary team members and licensed nursing staff (LPN and RN) regarding updating and implementing the care plan. The in-service includes, but is not limited to, the importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs. The Director of Nursing/designee will conduct an audit of 25% of resident care plans weekly for 4 weeks and monthly for 2 months to ensure that interventions are appropriate and reflect the individual needs of each resident and they are being implemented appropriately. Any issues	

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F 656	Continued From page 37 laryngectomy tube and usually the care plan documents what needs to be done, suction prn (as needed), make sure care is provided, notify the physician of any secretions or signs of infection, and monitor the resident's temperature and oxygen level. On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Planning - Comprehensive Person-Centered" documented, "13. The comprehensive care plan will: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Be culturally competent and trauma-informed as applicable e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h. Promote resident safety; i. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and j. Reflect currently recognized standards of practice for problem areas and conditions." Reference: (1) A laryngectomy tube is used after the removal of the larynx (the voice box in the throat). This information was obtained from the website: https://medlineplus.gov/ency/article/007398.htm	F 656	identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. Date of Compliance: 11/3/23	

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2. For Resident #108 (R108), the facility staff failed to implement the resident's comprehensive care for pressure injury assessment and documentation.

R108 was admitted to the facility on 5/27/23 with a diagnosis of a stage four pressure injury on the sacral region (1). R108's comprehensive care plan dated 6/4/23 documented, "I have actual impairment to skin integrity r/t (related to) right ischium (inaccurate documentation of location). Assess/Monitor/Document wound: size, depth, margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis per facility protocols..."

A review of R108's clinical record failed to reveal thorough assessments of the pressure injury and progress in wound healing in August 2023 and September 2023. The only documentation regarding the resident's skin was a weekly skin observation dated 8/7/23 that documented no open areas, a weekly skin observation dated 8/15/23 that documented an open area on the left buttock, a weekly skin observation dated 8/21/23 regarding another skin concern but did not contain any documentation regarding the pressure injury, a weekly skin observation dated 8/29/23 that documented no open areas and a weekly skin observation dated 9/6/23 that documented an open area on the left buttock.

On 9/20/23 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated assessments of pressure injuries should include a description of the wound, the

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measurement of the size, any odor, the color, the presence of drainage, and the stage if the nurse is a RN (registered nurse).

On 9/21/23 at 9:16 a.m., another interview was conducted with LPN #3. LPN #3 stated, "The purpose of the care plan is the action of the care while they [the residents] are here." In regard to care plan implementation, LPN #3 stated the nurses have access to the care plans and the MDS (minimum data set) staff is available if nurses have questions about the care plan.

On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

Reference:
(1) "Stage 4 Pressure Injury: Full-thickness skin and tissue loss.
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

3. For Resident #52, the facility staff failed to develop the comprehensive care plan for bed rails.

Resident #52 was admitted to the facility on 6/19/23 with diagnosis that included but were not limited to: hemiplegia, hemiparesis, morbid obesity and congestive heart failure.

A review of the comprehensive care plan dated

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6/19/23, which revealed, "FOCUS: The resident is at risk for falls related to limited mobility. INTERVENTIONS: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance."

A review of the physician orders revealed no order for bed rails.

Resident #52 was observed resting in bed on 9/19/23 at 1:20 PM, 9/20/23 at 8:50 AM and 9/21/23 at 8:00 AM with bilateral one quarter rails raised on bed.

A review of the facility's "Side Rail Risk and Entrapment" form dated 6/19/23 revealed "Recommendations: Use both upper 1/4 rails for independent bed mobility. Reason for side rail use: to assist with bed positioning."

An interview was conducted on 9/19/23 at 1:20 PM with Resident #52. When asked if he used the rails, Resident #52 stated, "Yes, I use the rails to turn in bed and to position myself."

An interview was conducted on 9/21/23 at 9:15 AM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, the purpose of the care plan is the action of the care while they are here and that bed rails should be on the care plan due to the resident's need to use them for turning and positioning.

On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings.

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No further information was presented prior to exit.
4. For Resident #219, the facility staff failed to implement the comprehensive care plan during medication administration.

Resident #219 was admitted on 9/8/23 and had the diagnoses of high blood pressure (HTN), atrial fibrillation (Afib), lymphedema and non-pressure chronic ulcer of the skin.

A review of the comprehensive care plan dated 9/19/23 revealed the following:
"(Resident #219) is at risk for potential nutritional problems..." Interventions included one dated 9/19/23 for "Meds and Labs as ordered."
"I have actual impairment to skin integrity...." Interventions included one dated 9/19/23 for "Administer medications, supplements and treatments as ordered...."
"(Resident #219) has hypertension (HTN)." Interventions included one dated 9/19/23 for "Give anti hypertensive medications as ordered...."

A review of the physician's orders revealed the following:

(1) Aspirin an 81 mg (milligrams) tablet once daily. Order dated 9/8/23.
(2) Valsartan an 80 mg tablet once daily. Order dated 9/8/23.
(3) Vitamin D3 a 25 mcg (micrograms) tablet. Give two tablets once daily. Order dated 9/9/23.
(4) Zinc a 220 mg tablet once daily for wound healing. Order dated 9/13/23.

On 9/20/23 at 9:05 AM, the medication administration observation was conducted with

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LPN #10 (Licensed Practical Nurse), for Resident #219. Upon review of the physician's orders and the Medication Administration Record (MAR) for September 2023 revealed that the Aspirin, Valsartan, Vitamin D3 and Zinc were ordered but were not prepared and administered on observation.

On 9/20/23 at 1:10 PM, an interview was conducted with LPN #10. She stated that she thought she pulled and administered the above medications. She stated that she did not know how she missed them.

On 9/20/23 at 1:50 PM, a second follow up interview was conducted with LPN #10. When asked if the care plan documented to administer medications as ordered, and the medications were missed, was the care plan being followed, she stated that it was not. When asked what was the purpose of the care plan, she stated so that everyone knows how to care for the resident.

The facility policy "Care Planning - Comprehensive Person-Centered" was reviewed. This policy documented, "..... A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident....2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process...."

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On 9/20/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #4, the Regional Nurse Consultant, were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Aspirin - Is used to prevent heart attacks, strokes, and reduce the risk of death from a heart attack or stroke.
Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html

(2) Valsartan - Is used alone or in combination with other medications to treat high blood pressure.
Information obtained from https://medlineplus.gov/druginfo/meds/a697015.html

(3) Vitamin D3 - Is used as a dietary supplement when the amount of vitamin D in the diet is not enough...is also used along with calcium to prevent and treat bone diseases...
Information obtained from https://medlineplus.gov/druginfo/meds/a620058.html

(4) Zinc - Is an essential trace element commonly found in red meat, poultry, and fish. It is necessary in small amounts for human health, growth, and sense of taste. Zinc is found throughout the body. The body doesn't store excess zinc, so it must be obtained from the diet. It's needed for immune function, wound healing, blood clotting, thyroid function, and much more. It

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also plays a key role in maintaining vision and might have effects against viruses. Information obtained from https://medlineplus.gov/druginfo/natural/982.html)

5. For Resident #62 (R62), the facility staff failed to implement the comprehensive care plan to use a cigarette extender and smoking apron while smoking.

On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 6/20/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. Section J documented no current tobacco use.

On 9/19/2023 at 2:30 p.m., an observation was made of R62 in the facility courtyard smoking. R62 was observed smoking two cigarettes during the supervised smoke break without using a cigarette extender or smoking apron.

On 9/19/2023 at 3:56 p.m., an interview was conducted with R62. R62 stated that they had smoked for years and had been smoking at the facility since admission. R62 stated that the facility stored their cigarettes and lighter in a box that they took at during the smoking times. R62 stated that they had a cigarette extender that they kept in their room and they took it outside "sometimes." R62 stated that the facility used to require them to use smoking aprons at one time but they were not required anymore.

On 9/19/2023 at 4:30 p.m., an additional observation was conducted of R62 in the facility

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courtyard smoking. R62 was observed smoking during the supervised smoke break without the use of a cigarette extender or smoking apron.

The comprehensive care plan for R62 documented in part, "History of smoking and current smoker
Date Initiated: 12/06/2019. Revision on: 08/09/2023." Under "Interventions" it documented in part, "Assist/ensure cigarette extender is used during designated smoke times. Date Initiated: 03/29/2022. Revision on: 01/11/2023... Provide with a smoking apron and assist to put on. Date Initiated: 02/19/2020. Revision on: 01/11/2023..."

The "Smoking-Resident Safety Evaluation" for R62 dated 2/9/2023 documented in part, "...Tobacco Utilization: 1. Does the resident use tobacco products? Yes. Does the facility allow smoking? Yes. Tobacco products utilized: Cigarettes/Cigars... Resident adaptive equipment needs: a. Smoking apron, b. Cigarette holder, c. Supervision..."

On 9/19/2023 at 3:45 p.m., an interview was conducted with CNA (certified nursing assistant) #11. CNA #11 stated that residents met in the room by the courtyard prior to going out to smoke at the scheduled times and were supposed to put on smoking aprons prior to going out if they required them. She stated that she knew which residents required smoking aprons because she worked with them so often. She stated that she knew that R62 had a cigarette extender that they kept in their room to bring with them.

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2.

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LPN #2 stated that the purpose of the care plan was to keep track of the residents care in the facility and contained all aspects of their care. She stated that the care plan should be implemented to make sure the resident was getting the proper care and treatment.

On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN #3. LPN #3 stated that the purpose of the care plan was to provide an action of care and documented why the resident was there. She stated that the care plan was implemented by the nurses having access to the care plan if they needed it and having MDS available if they had any questions about the care plan.

On 9/20/2023 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

6. For Resident #76 (R76), the facility staff failed to implement the comprehensive care plan to ensure the call light was within reach.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/15/2023, the residents cognition status was not assessed. Section G documented R76 requiring supervision for walking in the room and corridor and extensive assistance of one person for toileting. The resident was assessed as being frequently incontinent.

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On 9/19/2023 at 12:34 p.m., an observation was made of R76's bathroom. R76 was observed sitting on the side of their bed with a walker in front of them. The wall beside R76's commode contained a call light panel with no pull cord attached. The call light was observed to not be accessible to the resident from the floor if needed. At that time an interview was conducted with R76. R76 stated that the cord had come out of the wall over a week ago and they had taken the cord up to the nurses station and given it to the nurse on duty at the time and asked them to have maintenance repair it. R76 stated that they used the bathroom and was scared that if they fell they would not be able to call anyone because they would not be able to reach the call light. R76 stated that the nursing staff had told them several times that they would have someone come fix the cord on the light but no one had come.

Additional observations of R76's bathroom were made on 9/20/2023 at 8:55 a.m. and 9/20/2023 at 1:45 p.m. The call light in the bathroom remained without a pull cord accessible to the resident from the floor if needed.

The comprehensive care plan for R76 documented in part, "(Name of R76) is at risk for falls r/t (related to) limited mobility. Date Initiated: 05/30/2023. Revision on: 06/07/2023." Under "Interventions" it documented, "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 05/30/2023."

On 9/20/2023 at 2:13 p.m., an interview was

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conducted with CNA (certified nursing assistant) #8. CNA #8 stated that they were not aware of any problems with any resident call lights on the unit. She stated that all residents should have access to the call light and if there were any problems with the call light they put in requisitions to have maintenance come to repair them.

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to keep track of the residents care in the facility and contained all aspects of their care. She stated that the care plan should be implemented to make sure the resident was getting the proper care and treatment.

On 9/20/2023 at 2:51 p.m., an interview was conducted with OSM (other staff member) #6, the director of maintenance. OSM #6 stated that they utilized a computer system which all staff were able to enter work orders into for repairs. He stated that he checked the system at least once a day and added comments for repairs needed or closed out completed repairs. OSM #6 checked his maintenance requests for R76's bathroom call light and stated that it had not been reported to him. He observed the call light in R76's bathroom with no pull cord and stated that there should be a cord in place for the resident to be able to access it if needed.

On 9/21/2023 at 1:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

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7. For Resident #11 (R11), the facility staff failed to develop the comprehensive care plan for hospice services.

On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 8/5/2023, the resident was coded as receiving hospice services while a resident at the facility.

The comprehensive care plan for R11 failed to evidence hospice services.

The physician orders for R11 documented in part, "Admit to (Name and phone number of hospice). Order Date: 7/5/2023."

The progress notes documented in part, "7/11/2023 11:31 (11:31 a.m.) Note Text : Readmission note for (age and sex of R11) LTC (long term care) under hospice services recently hospitalized r/t (related to) seizures..."

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to keep track of the residents care in the facility and contained all aspects of their care. She stated that MDS staff and nursing both developed the care plans. She stated that she was not sure if hospice was on the care plan or not because hospice residents at the facility were more functional than the ones they normally worked with.

On 9/20/2023 at 2:34 p.m., an interview was conducted with RN (registered nurse) #5, MDS

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coordinator. RN #5 stated that MDS was responsible for the comprehensive care plan. She stated that the MDS staff care planned anything that triggered from the MDS assessment and the nursing staff, dietician, social worker and activities added additional things. She stated that the care plan purpose was to guide the residents care and hospice residents should have a care plan addressing hospice services. She reviewed R11's care plan and stated that she did not see anything regarding hospice.

On 9/20/2023 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

8. For Resident #16 (R16), the facility staff failed to implement the comprehensive care plan to monitor weights.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/7/2023, the resident was coded as "no or unknown" for weight loss in the past 6 months. The resident was assessed as receiving a therapeutic diet.

The comprehensive care plan for R16 documented in part, "(Name of R16) is at risk for hydration/nutrition imbalance in setting of therapeutic diet, h/o (history of) obese BMI (body mass index), and multiple chronic disease states, hx (history) of lymphedema, h/o significant wt (weight) loss. Date Initiated: 11/06/2017. Revision

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on: 03/08/2023." Under "Interventions" it documented in part, "... Review weights and notify physician and responsible party of significant weight change. Date Initiated: 11/06/2017."

The physician orders for R16 documented in part, "No labs, no vitals. Continue monthly weights. Order Date: 3/3/2023."

The weight summary for R16 documented a weight of 179.0 lbs (pounds) on 3/6/2023 and a weight of 179.4 lbs on 9/6/2023. The weight summary failed to evidence weights obtained for 4/2023, 5/2023, 6/2023, 7/2023 or 8/2023.

Review of the clinical record failed to evidence refusals of weights between 4/1/2023-8/31/2023.

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to keep track of the residents care in the facility and contained all aspects of their care. She stated that the care plan should be implemented. She stated that residents were weighed at least monthly unless ordered more frequently and if they refused weights it was documented in the progress notes.

On 9/20/2023 at 2:13 p.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that all residents were weighed at least monthly and more often if the nurses told them it was needed. She stated that if the resident refused they waited and attempted later that day and if they still refused they let the nurse know.

On 9/21/2023 at 1:45 p.m., ASM (administrative

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F 656	Continued From page 52 staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	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:	F 657		11/3/23

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F 657	Continued From page 53 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to review and revise the care plans for three of 40 residents in the survey sample, Residents #13, 108 and #83. The findings include: 1. For Resident #13 (R13), the facility staff failed to review and revise the comprehensive care plan after a resident to resident altercation on 8/21/2023. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 6/24/2023, the resident scored 6 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section E documented no behaviors other than rejection of care. The progress notes for R13 documented in part, - "8/21/2023 13:23 (1:23 p.m.) Note Text : Resident got into a physical altercation with another resident in resident's room. As a result this resident received a contusion to the right eye. Resident was medicated with Tylenol for pain. Resident alert and verbal. able to make all his needs known. Currently up in his wheelchair visiting. No s/s (signs/symptoms) of distress at this time." - "8/21/2023 13:50 (1:50 p.m.) Note Text : SW (social worker) spoke with resident regarding incident in facility, resident stated he was agitated due to other's resident's attitude towards him and resident came into his space to hit him in the face. SW explained that the residents will need to be separated, and physical violence is not	F 657	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. The care plan of Residents #13 and #108 were updated to include a physical altercation with another resident. The care plan of Resident #83 was updated to include the use of the anti-anxiety medication, diazepam. 2. Rosedale has identified that all residents are at risk from this deficient practice. A process has been developed and implemented in the daily interdisciplinary team meeting to identify resident care needs, ensure a care plan has been revised to meet individualized needs and the results of implementation are being tracked and addressed appropriately. 3.The Director of Nursing/designee has in-serviced nursing leadership, interdisciplinary team members and licensed nursing staff (LPN and RN) regarding revising the care plan. The in-service includes, but is not limited to, updates with any changes for each resident and care plans being reflective of individualized care needs. 4. The Director of Nursing/designee will conduct an audit of 25% of resident care plans weekly for 4 weeks and monthly for 2 months to ensure that interventions are appropriate and have been revised to	

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F 657	Continued From page 54 allowed in the facility at any time. Nursing completed skin check and injuries sustained, appropriate follow up concluded. Mother was called regarding matter, resident interview complete. Mother spoke with admin (administrator), DON (director of nursing), and SW about incident, police were called and no charges made." Review of the facility investigation dated 8/21/2023 documented a summary of the incident, resident statements, nursing notes, and social services notes. The comprehensive care plan for R13 failed to evidence a review or revision related to the resident to resident altercation on 8/21/2023. On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to document and keep track of the residents care while at the facility. She stated that the nurses and MDS reviewed and revised the care plan. On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN #3. LPN #3 stated that the purpose of the care plan was to provide an action of care for the resident. She stated that the comprehensive care plan was completed by MDS. She stated that the care plan should be revised after a resident to resident altercation so the staff knew the behaviors occurred. On 9/21/2023 at 9:48 a.m., an interview was conducted with OSM (other staff member) #4, the director of social services. OSM #4 stated that when a resident to resident altercation occurred	F 657	reflect the individual needs of each resident and they are being implemented appropriately. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 11/3/23	

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they interviewed the residents, made sure nursing did a physical assessment and discussed a room change if needed to make sure the residents were kept safe. She stated that social services may update the care plan if the altercation was physical because of the aggressive behaviors. She stated that the care plan would be updated for both residents.

The facility policy, "Care Planning-Comprehensive Person-Centered" undated, documented in part, "... 13. The comprehensive care plan will: a. Incorporate identified problem areas... 15. Behavior Intervention Plan (BIP) may be developed when a resident exhibits behaviors that place the resident, other residents, or staff at risk or impedes on their rights. a. The BIP will be developed in collaboration with the resident, interdisciplinary team, and mental health professionals as appropriate. b. The BIP will be incorporated into the resident's comprehensive care plan. i. The BIP will be reviewed and updated as needed to address change in the resident behaviors. c. The BIP will clearly identify the behaviors being addressed, interventions/approaches to reduce behaviors, and expected outcomes. The BIP will also include consequences and action that may be taken should the resident not comply with the agreed expectations..."

On 9/21/2023 at 1:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was obtained prior to exit.
2. For Resident #108 (R108), the facility staff

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failed to review and revise the resident's comprehensive care plan after a physical altercation with another resident on 8/21/23.

A review of R108's clinical record revealed a progress note dated 8/21/23 that documented, "Resident was involved in a resident on resident altercation this afternoon. According to (R108), the other resident involved slapped him on his upper shoulder/chest area after a verbal altercation took place and, in relation, (R108) hit the other resident in the face. (R108) obtained minor scratches, delivered by other resident, during the scuffle. He was bleeding from one scratch on his left forearm and had a 2-3 inch scratch on his left upper arm. The superficial wounds were cleaned but did not need to be dressed. His RP (responsible party)/Emergency Contact (mother) was contacted by this nurse and the situation was explained to her. She expressed no concerns at that time. Both residents are being observed to help prevent further issues."

A review of R108's comprehensive care plan revised on 8/29/23 failed to reveal the care plan was reviewed and revised regarding the physical altercation.

On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated, "The purpose of the care plan is the action of the care while they [the residents] are here." LPN #3 stated residents' care plans should be reviewed and revised after a physical altercation, so employees know the residents have a behavior.

On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

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(the director of nursing) were made aware of the above concern.

3. For Resident #83 (R83), the facility staff failed to review and revise the resident's comprehensive care plan for the resident's use of the anti-anxiety medication, diazepam.

A review of R83's clinical record revealed a physician's order dated 8/4/23 for diazepam (1) 5 mg (milligrams)- one tablet by mouth every eight hours as needed for 180 days for anxiety. A review of R83's August 2023 and September 2023 MARs (medication administration records) revealed the resident was administered as needed diazepam 28 times in August 2023 and 24 times in September 2023. A review of R83's comprehensive care plan revised on 8/15/23 failed to reveal the care plan was reviewed and revised for the resident's use of anti-anxiety medication.

On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated, "The purpose of the care plan is the action of the care while they [the residents] are here." LPN #3 stated residents' care plans should be reviewed and revised for the use of anti-anxiety medication so staff can monitor for behaviors and changes in behaviors.

On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

Reference:
(1) Diazepam is used to treat anxiety. This information was obtained from the website:

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F 657	Continued From page 58 https://medlineplus.gov/druginfo/meds/a682047.html	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, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for two of 40 residents in the survey sample, Residents #106 and #219. The findings include: 1.a. For Resident #106 (R106), the facility staff failed to obtain a physician's order for pressure injury treatments that were completed. A review of R106's clinical record revealed nurses' notes that documented the following: -5/22/23 "It was reported by therapy that resident has large ulcers on heels. On arrival resident has unstageable ulcers (injuries) (1) on both heels and stage 1 (1) ulcer on both side of the foot and ankle. Wiped down with skin prep." -6/7/23 "Resident was noted to have an unstageable ulcer (pressure injury) measuring 7 cm (centimeters) x 10 cm in circumference in the sacrum. 5 cm x 7 cm stage II (1) ulcer on the lateral aspect of the left upper thigh, fluid filled in the center and surrounding tissues red and irritated. 4 cm x 4.5 cm unstageable ulcer on	F 658	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Residents #106 and #219 no longer reside at the facility. 2. An audit has been performed on all current residents to identify residents with pressure injuries to ensure physician□s orders for pressure injury treatments are obtained and resident skin assessments have been accurately documented upon admission. An audit has been performed on all current residents to ensure medications are being administered as ordered by the physician. Any discrepancies have been corrected. 3. The Director of Nursing/designee has educated licensed nursing staff on meeting professional standards of quality. The in-service includes, but is not limited to, obtaining a physician□s order for	11/3/23

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F 658	Continued From page 59 both heels. Scattered bruises on the left lower leg and foot. Sacral and left hip wound were cleansed with wound cleanser and dry dressing applied." Further review of R106's clinical record failed to reveal the nurses' obtained physician's orders for the above treatments that were completed. On 9/20/23 at 10:10 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated the doctor has to give orders for how to clean wounds. On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Medication and Treatment Orders" documented, "1. Medications will be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state." Reference: (1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear... Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin.... Stage 2 Pressure Injury: Partial-thickness skin	F 658	pressure injury treatments, accurately documenting a resident□s skin assessment upon admission, and administering medications as ordered by the physician. 4. The Director of Nursing/designee will conduct an audit of all residents weekly for 4 weeks and monthly for 2 months to ensure that any resident with a pressure injury has a physician order for pressure injury treatments. The Director of Nursing/designee will also audit any new admissions weekly for 4 weeks and monthly for 2 months to ensure skin assessments are accurately documented upon admission. The Director of Nursing/designee will also audit 25% of resident□s medication administration records weekly for 4 weeks and monthly for 2 months to ensure medications are being administered as ordered by the physician. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. The date of compliance is: 11/3/23	

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loss with exposed dermis.
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss.
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue)..." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

1.b. For Resident #106 (R106), the facility staff failed to accurately document a resident's refusal of a skin assessment upon admission. Instead, the nurse documented the resident presented with no skin issues.

R106's admission screener (assessment) dated 5/18/23 documented the resident had no skin issues. A physical therapy note dated 5/19/23 documented R106 presented with unstageable pressure injuries (1) on both heels.

On 9/20/23 at 10:10 a.m., an interview was conducted with RN #4 (the nurse who documented the admission screener assessment). RN #4 stated R106 refused a skin assessment on the day of admission, but per the report she received from the transferring facility, the resident did not have skin issues, so she documented no skin issues on the admission assessment. RN #4 stated that instead of documenting no skin issues, she should have documented R106 refused the skin assessment on 5/18/23.

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On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Documentation of Wound Treatments" documented, "1. Wound assessments are documented upon admission..."

Reference:
(1) "Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss.
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue)..." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
2. For Resident #219 the facility staff failed to administer four medications as ordered by the physician.

A review of the physician's orders revealed the following:

(1) Aspirin an 81 mg (milligrams) tablet once daily. Order dated 9/8/23.
(2) Valsartan an 80 mg tablet once daily. Order dated 9/8/23.
(3) Vitamin D3 a 25 mcg (micrograms) tablet. Give two tablets once daily. Order dated 9/9/23.
(4) Zinc a 220 mg tablet once daily for wound healing. Order dated 9/13/23.

On 9/20/23 at 9:05 AM, the medication administration was conducted with LPN #10 (Licensed Practical Nurse), for Resident #219.

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Upon review of the physician's orders and the Medication Administration Record (MAR) for September 2023 revealed that the Aspirin, Valsartan, Vitamin D3 and Zinc were ordered but were not prepared and administered on observation. They were signed out as being administered.

On 9/20/23 at 1:10 PM, an interview was conducted with LPN #10. She stated that she thought she pulled and administered the above medications, and is why they were signed out as being administered. She stated that she did not know how she missed them.

On 9/20/23 at 1:50 PM, a second follow up interview was conducted with LPN #10. She stated that the process for medication administration included the five rights of making sure you have the right dose, right time, right route, right resident and the right medication. She stated that since there were medications that were missed, the five rights were not followed.

The facility policy "Adverse Consequences and Medication Errors" documented, "...."Medication Error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services....5. Examples of medications errors include: a. omission - a drug is ordered but not administered; b. unauthorized drug - a drug is administered without a physician's order; c. wrong dose... d. wrong route of administration... e. wrong dosage form... f. wrong drug... g. wrong time; and/or; h. failure to follow manufacturer instructions and/or

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F 658	Continued From page 63 accepted professional standards..." On 9/20/23 at 3:30 PM, an end-of-day meeting was conducted with ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #4, the Regional Nurse Consultant, were made aware of the findings. No further information was provided by the end of the survey. References: (1) Aspirin - Is used to prevent heart attacks, strokes, and reduce the risk of death from a heart attack or stroke. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html (2) Valsartan - Is used alone or in combination with other medications to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a697015.html (3) Vitamin D3 - Is used as a dietary supplement when the amount of vitamin D in the diet is not enough...is also used along with calcium to prevent and treat bone diseases... Information obtained from https://medlineplus.gov/druginfo/meds/a620058.html (4) Zinc - Is an essential trace element commonly found in red meat, poultry, and fish. It is necessary in small amounts for human health, growth, and sense of taste. Zinc is found throughout the body. The body doesn't store	F 658		

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F 658	Continued From page 64 excess zinc, so it must be obtained from the diet. It's needed for immune function, wound healing, blood clotting, thyroid function, and much more. It also plays a key role in maintaining vision and might have effects against viruses. Information obtained from https://medlineplus.gov/druginfo/natural/982.html)	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow the plan of care for transporting a resident which resulted in an injury for one of 40 residents in the survey sample, Resident #33. The resident sustained a fracture of the right femur (1) which constituted harm, cited at past non-compliance. The findings include: For Resident #33 (R33), the facility staff failed to provide support to the resident's feet while transporting them in the wheelchair in the facility hallway, which resulted in the resident's feet dropping to the floor which caused R33 to fall	F 684	Past noncompliance: no plan of correction required.	

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from the wheelchair and subsequently sustained a fractured femur.

On R33's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 8/10/2023, the resident was not assessed for cognition. Section G documented R33 using a wheelchair and having range of motion impairment on one side in the upper and lower extremity. Section GG documented R33 being non-ambulatory and using a manual wheelchair. Section J documented R33 having a fall with fracture related to a fall in the past 6 months.

On the residents MDS prior to the injury, a quarterly assessment with an ARD of 5/25/2023, the resident was assessed as being modified independent in making daily decisions. Section G documented R33 using a wheelchair and having range of motion impairment on one side in the upper extremity and both side in the lower extremities. Section GG documented R33 being non-ambulatory and using a manual wheelchair. It further documented R33 being dependent to wheel 50 feet with two turns and wheel 150 feet in a corridor or similar space. Section J documented R33 not having any falls.

On 9/21/2023 at 8:34 a.m., an interview was conducted with R33. R33 stated that they had not really been told what happened that day but remembered that their feet were hanging off the wheelchair and they just went forward from the chair onto the floor.

The progress notes for R33 documented in part,
- "7/28/2023 12:29 (12:29 p.m.) Note Text: CNA (certified nursing assistant) propelling resident to

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the shower room in her w/c (wheelchair) at 1030am when residents feet with sneakers on fell to the floor and caused resident to fall out of the w/c in the hallway. Assisted from floor by 3 staff members. Denies pain. States she feels fine. ROM (range of motion) performed without any new limitation or pain. RP (responsible party) and DR (doctor) notified. Will cont (continue) to monitor."
- "7/28/2023 15:22 (3:22 p.m.) Note Text: Resident c/o (complains of) pain 6/10 (six out of possible ten) to right groin and thigh. Voltaren gel applied to area. NP (nurse practitioner) called and notiifed [sic] with N.O. (new order) Right hip and right femur X-RAY STAT (now) s/p (status post) fall. RP (responsible party) aware. X-ray called in and awaiting arrival."
- "7/28/2023 22:47 (10:47 p.m.) Note Text: X-ray to right hip and femur completed this shift, awaiting for result. Resident complained of level 2/10 pain when moving in the bed was medicated with 2 Tylenol with good relief."
- "7/29/2023 07:00 (7:00 a.m.) Note Text: Received X ray result finding sub capital fracture acute of the right femoral neck without dislocation left (name of physician) message via on call, waiting for call back. report given to oncoming nurse."
- "7/29/2023 07:52 (7:52 a.m.) Note Text: N.O. received to send resident to ED (emergency department) r/t (related to) r (right) femur fx (fracture)."
- "8/2/2023 15:30 (3:30 p.m.) Note Text: Readmit to facility from Acute Care Hospital for repair and treatment of right hip fracture. Surgical procedure was performed to right hip, dressing dry and intact, no bleeding. Vital signs: 98.7 (temperature),98 (pulse),18 (respirations),118/61 (blood pressure), 94% (oxygen saturation). Skin

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warm and dry, moving right leg slowly. positive pedal pulses."

The comprehensive care plan for R33 documented in part, "ADL (activities of daily living) Self care deficit as evidenced by related to weakness, femur fracture. Date Initiated: 05/18/2019. Revision on: 08/02/2023." The care plan further documented, "At risk for falls, had an actual fall due to weakness. Date Initiated: 05/18/2019. Revision on: 08/02/2023."

Review of the fall investigation completed for R33 dated 7/28/2023 documented in part, "...Incident Description: Nursing Description: CNA propelling resident to the shower room in her w/c at 1030am when residents feet with sneakers on fell to the floor and caused resident to fall out of the w/c in the hallway. Assisted from floor by 3 staff members. Denies pain. States she feels fine. ROM performed without any new limitation or pain. RP and DR notified. Will cont to monitor... Immediate Action Taken: Description: Resident did not hit her head. Head to toe assessment done. No visible injury noted. V/S (vital signs) and ROM WNL (within normal limits). Assisted back to w/c. Complaining of right hip, leg pain. NP notified. Order received and carried out to order STAT x-ray of right hip and right femur. RP notified. Pain medication administered. Leg rests provided on wheelchair. Resident taken to Hospital? N (no)...No injuries observed post incident."

On 9/20/2023 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, stated that the CNA who was pushing R33 in the wheelchair on 7/28/2023 when the injury occurred no longer worked at the facility and could not be

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interviewed. ASM #4, the regional nurse consultant stated that the facility had an action plan that had been put in place after R33's injury and would provide it for review.

On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they were unsure if they were working the day of R33's injury or not. She stated that the team had discussed the fall and injury in their morning meeting after they had been sent out to the hospital. She stated that R33 was wheelchair bound prior to the injury and required staff to push them around the halls. She stated that any residents that were unable to propel themselves in the wheelchair should have leg rests on the chairs to support the feet.

On 9/21/2023 at 10:18 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that they were in the building on 7/28/2023. She stated that the staff notified them that they were calling the nurse practitioner and had gotten the order for the stat x-ray. She stated that the staff reported to her that they were taking the resident for their scheduled shower, and they had put their feet down with their shoes on and went forward. She stated that R33 was a one person assist, wheelchair bound and required staff to propel them in the wheelchair prior to the incident. She stated that from their staff interviews and investigation they had determined that the CNA did not have the leg rests on the wheelchair and had the resident holding their feet up. She stated that this led them to put an action plan in place. She stated that the expectation for staff was to make sure that the leg rests were in place prior to transporting the resident.

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On 9/21/2023 at 10:35 a.m., an interview was conducted with CNA #9. CNA #9 stated that anytime they needed to transport a resident who required them to push their wheelchair they made sure they had leg rests on the chair. She stated that if the resident did not have leg rests, they went to the therapy department to obtain some. She stated that they did this so the resident's feet did not drag because it could cause skin breakdown and was also a safety issue.

On 9/21/2023 at 10:41 a.m., an interview was conducted with CNA #10. CNA #10 stated that residents had leg rests on the wheelchair for use during transport by staff unless therapy determined that the resident needed to strengthen their lower extremities by self-propelling. She stated that R33 was able to use their arms to propel themselves in the wheelchair short distances at times.

On 9/21/2023 at 11:47 a.m., an interview was conducted with RN (registered nurse) #6. RN #6 stated that they were in the hallway administering medications on 7/28/2023 when the CNA was pushing R33 in the wheelchair. She stated that the CNA came past them with R33 in the wheelchair and then she saw R33 roll out of the chair a few steps in front of her. She stated that R33 did not hit their head, did not complain of any pain, or have any abnormalities in vital signs or the head-to-toe assessment so they had just monitored them at that time. She stated that R33 was in the wheelchair without leg rests with their feet hanging down and had sneaker on with grips on them and they thought when their foot dropped down on the carpet it had gripped the carpet and propelled them forward out of the chair. She

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stated that she had advised the CNA to go to the room to get the leg rests for the chair, but they could not be located. She stated that R33 was fine until later in the shift when they started to complain of pain, so they had contacted the nurse practitioner and ordered the x-ray. She stated that R33 normally was always propelled in the wheelchair by staff prior to the incident and they had only seen them propel only a few steps in the hallway.

On 9/21/2023 at approximately 8:00 a.m., ASM #1, the administrator provided an action plan for R33 with a completion date of 8/4/2023. Review of the action plan documented corrective action plan for R33, identification of other residents potentially affected, measures the facility will take, quality assurance plans to monitor facility performance and a completion date for the action plan.

On 9/21/2023 at approximately 8:20 a.m., a request was made to ASM #1, the administrator for evidence of completion of the action plan.

On 9/21/2023 at 8:40 a.m., ASM #1 provided a folder with evidence of completion of the action plan. Review of the action plan documented: 1) one on one education to the CNA involved regarding application of leg rest/footrest on any residents that are dependent with locomotion. 2) An audit completed of all residents in the facility identifying other residents potentially affected. 3) Audits completed on 8/11/2023, 8/18/2023, 8/25/2023, 9/1/2023, 9/8/2023 and 9/15/2023 of dependent wheelchair residents to determine if leg rests were available and 25% care plan audits. It further documented education provided to licensed staff members (CNA, LPN, RN) on

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"wheelchair dependent residents- ensure leg rests are available for chair & place order for leg rests if not available" conducted by the director of nursing on 8/3/2023. 4) An ad hoc QAPI (quality assurance performance improvement) meeting agenda/summary dated 8/3/2023 documenting the administrator, MDS coordinator, unit manager and director of nursing meeting regarding "Management of transporting dependent wheelchair residents in wheelchairs and where wheelchair dependence is documented."

Review of the plan of correction provided by ASM #1 for R33's injury on 7/28/2023 documented a date of compliance of 8/4/2023. Verification of the facility plan of correction was completed by observations, staff interviews and review of the facility audits, staff education and resident audits. No concerns were identified.

Observations of current residents being transported by facility staff were conducted during the survey dates. There were no current concerns identified.

On 9/21/2023 at 12:08 p.m., ASM #1, the administrator and ASM #4, the regional nurse consultant were made aware of the concern for harm. No further information was provided prior to exit.

Based on the acceptable plan of correction, all components of the plan verified, and no concerns identified during the survey, this deficient practice is cited at past non-compliance.

Reference:
(1) femur fracture
You had a fracture (break) in the femur in your

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F 684	Continued From page 72 leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide care and services to prevent and treat pressure injuries for three of 40 residents in the survey sample, Residents #106, #108 and #96. For Resident #106, the facility staff failed to assess the resident for risk for pressure injuries, failed to document pressure injuries, failed to obtain physician's orders for the treatment of the pressure injuries, and failed to implement interventions to prevent	F 686	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Residents #106 and #96 no longer reside at the facility. Resident #108 has received care and services to prevent and treat pressure injuries.	11/3/23

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F 686	Continued From page 73 further pressure injuries, which constituted harm. The findings include: 1. For Resident #106 (R106), upon admission on 5/18/23, the facility staff failed to assess the resident for risk for pressure injuries, failed to document pressure injuries on the sacrum, left hip, right heel and left heel, failed to obtain physician's orders for treatments for those pressure injuries, and failed to implement interventions to prevent further pressure injuries. On 6/8/23, the wound care physician identified more unstageable (1) pressure injuries on the right great toe and left great toe. R106 was admitted to the facility on 5/18/23. The admission screener assessment dated 5/18/23 documented R106 presented with no skin issues; however, during an interview with RN (registered nurse) #4, the nurse who documented the admission screener assessment, RN #4 stated R106 refused a skin assessment on 5/18/23 and she did not complete a skin assessment until 5/19/23. RN #4 stated that during the 5/19/23 skin assessment, she identified multiple pressure injuries, and they were later documented in a skin note dated 6/7/23. The pressure injuries documented in RN #4's skin note dated 6/7/23 were an unstageable pressure injury on the sacrum, an unstageable pressure injury on the right heel, an unstageable pressure injury on the left heel, and a stage two (1) pressure injury on the left hip. The facility staff failed to assess the resident's risk for pressure injuries (until 5/23/23 when the resident was assessed as being at moderate risk for pressure injuries), failed to develop a care	F 686	2. Rosedale has identified that all residents are at risk from this deficient practice. An audit has been conducted to identify any pressure injuries and to ensure treatment and services are being provided. A process has been developed and implemented to provide treatment and services to prevent/heal pressure ulcers. 3. The Director of Nursing/designee has educated licensed nursing staff (RNs and LPNs) on providing treatment and services to Prevent/Heal Pressure Ulcers. The in-service includes, but is not limited to, completing thorough assessments to assess the resident for risk of pressure injuries, documentation of pressure injuries, care planning pressure injuries, obtaining physician orders to implement interventions to prevent and treat pressure injuries, providing treatments per physician□s orders, assessing self-care of pressure injuries and providing oversight of self-care to ensure treatments are being completed. 4. The Director of Nursing/designee will conduct an audit of residents with a pressure injury weekly for 4 weeks and monthly for 2 months to ensure that they are receiving care and services to prevent and treat the areas. The Director of Nursing/designee will also audit any new admissions weekly for 4 weeks and monthly for 2 months to ensure skin assessments are accurately documented upon admission and any pressure injury is provided with treatment and services. Any	

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plan for pressure injuries (until 6/27/23), and failed to obtain physician's orders to implement interventions to prevent and treat pressure injuries (until 6/8/23). On 6/8/23, the wound care physician evaluated R106 and ordered treatments for six different pressure injuries. These pressure injuries included the four pressure injuries documented in RN #4's 6/7/23 skin note; an unstageable pressure injury on the sacrum, an unstageable pressure injury on the left hip, an unstageable pressure injury on the right heel and a deep tissue injury on the left heel, and two new pressure injuries which were an unstageable pressure injury on the right great toe and an unstageable pressure injury on the left great toe.

A hospital discharge summary dated 5/18/23 failed to reveal any documentation regarding pressure injuries. R106 was admitted to the facility on 5/18/23. No assessment for risk for pressure injuries was completed on the date of admission. R106's admission screener (assessment) dated 5/18/23 documented the resident had no skin issues. The baseline care plan triggers section of the screener revealed no focus, goals, or interventions related to R106's skin integrity.

R106's care plan initiated on 5/18/23 failed to document any information regarding skin integrity and pressure injuries, until 6/27/23.

A physical therapy evaluation dated 5/19/23 documented R106 was totally dependent with bed mobility and presented with unstageable bilateral heel pressure areas (injuries). Further review of R106's clinical record failed to reveal any further documentation regarding the bilateral heel

issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.

5. The date of compliance is: 11/3/23

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pressure injuries until 5/22/23. A nurse's note dated 5/22/23 documented, "It was reported by therapy that resident has large ulcers on heels. On arrival resident has unstageable ulcers (injuries) on both heels and stage 1 (1) ulcer on both side of the foot and ankle. Wiped down with skin prep." A review of physician's orders, the medication administration record and the treatment administration record for May 2023 failed to reveal any treatments for the pressure injuries.

A review of nurse practitioner and physician notes from 5/19/23 through 5/24/23 failed to reveal any documentation regarding pressure injuries. The notes dated 5/19/23, 5/22/23, 5/23/23 and 5/24/23 documented, "SKIN: No rash, ulcer or cyanosis. Warm and dry. No induration, nodules, or discoloration..."

A Braden scale for predicting pressure sore (injury) risk dated 5/23/23 had documented that R106 was at moderate risk for pressure injuries.

A review of physician's orders, the medication administration record, and the treatment administration record for May 2023 and June 2023 failed to reveal any treatments for any pressure injuries until 6/8/23.

Physician notes dated 6/2/23 and 6/7/23 documented, "SKIN: (Name) indicated that patient has dark area on both heels. Wound care team to follow. Warm and dry. No induration, nodules, or discoloration..."

A skin note dated 6/7/23 and signed by RN (registered nurse) #4 (the nurse who documented the admission screener) documented, "Resident

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was noted to have an unstageable ulcer (pressure injury) measuring 7 cm (centimeters) x 10 cm in circumference in the sacrum. 5 cm x 7 cm stage II (1) ulcer on the lateral aspect of the left upper thigh, fluid filled in the center and surrounding tissues red and irritated. 4 cm x 4.5 cm unstageable ulcer on both heels. Scattered bruises on the left lower leg and foot. Sacral and left hip wound were cleansed with wound cleanser and dry dressing applied."

A progress note signed by the wound care physician on 6/8/23 documented, "Physical Exam. Constitutional: The pulse has a regular rate and rhythm. The patient is afebrile. The patient appears well nourished and has a normal weight...Wound Assessments(s)
-Wound #1 Sacral is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 8 cm length x 9 cm width with no measurable depth, with an area of 72 sq (square) cm. There is Moderate amount of serous drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar...
-Wound #2 Left Hip is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 6 cm length x 3 cm width with no measurable depth, with an area of 18 sq cm. There is a None amount of drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar...
-Wound #3 Right Heel is an Unstageable Pressure Injury Obscured full-thickness and tissue loss Pressure Ulcer and has received a

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status of Not Healed. Initial wound encounter measurements are 6 cm length x 6 cm width with no measurable depth, with an area of 36 sq cm. There is a None amount of drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar...
-Wound #4 Left Heel is a Deep Tissue (1) Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 5 cm length x 6 cm width with no measurable depth, with an area of 30 sq cm. There is a None amount of drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% epithelialization...
-Wound #5 Right Great Toe is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 1 cm length x 1 cm width with no measurable depth, with an area of 1 sq cm. There is a None amount of drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar...
-Wound #6 Left Great Toe is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 1 cm length x 1 cm width with no measurable depth, with an area of 1 sq cm. There is a None amount of drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar..."

Weekly Wound Evaluations with an effective date of 6/8/23 and signed by LPN (licensed practical nurse) #3 on 6/9/23, documented similar assessments for all pressure injuries documented

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by the wound physician, documented the measurements were obtained by the wound care provider, and documented the pressure injuries as new skin concerns and facility acquired.

Treatment orders for all of the pressure injuries were not obtained until 6/8/23 and included:
1. Bactrim DS (double strength) (an antibiotic) 800-160 mg (milligrams)- one tablet by mouth two times a day for wound infection for 14 days.
2. Medihoney (medical grade honey)- Apply to left hip topically every evening shift for skin alteration. Cleanse area with wound cleanser, apply honey, cover with foam dressing.
3. Medihoney- Apply to sacrum topically every evening shift for skin alteration. Cleanse area with wound cleanser, apply medihoney, cover with foam dressing.
4. Paint bilateral great toes with betadine (antiseptic used to treat skin infections) every evening shift for skin alteration.
5. Paint bilateral heels with betadine every evening shift for skin alteration.

On 9/20/23 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who documented the 6/8/23 weekly wound evaluations). LPN #3 stated a Braden assessment, and a head-to-toe skin assessment should be completed for all residents upon admission. LPN #3 stated if a resident does present with a pressure injury on admission, then staff have to make sure the resident has an air loss mattress and nurses should check the hospital discharge instructions for wound care orders. LPN #3 stated that if the discharge instructions do not contain wound care orders, then nurses should call the doctor or nurse practitioner to obtain wound care orders. LPN #3

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stated that within 24 hours of admission, residents must have a second skin assessment in case the first nurse missed something. LPN #3 stated nurses are supposed to develop a care plan on admission and the care plan should include a risk for skin alteration for all residents and include pressure injuries if the resident has pressure injuries. LPN #3 stated that after residents are admitted, weekly skin observations should be conducted on all residents and nurses are required to look at every resident's skin. LPN #3 stated if a new area is observed, the nurse should assess the pressure injury, document the assessment, notify the doctor, notify the family, initiate a treatment order, and update the care plan. LPN #3 stated assessments of pressure injuries should include a description of the wound, the measurement of the size, any odor, the color, the presence of drainage, and the stage if the nurse is a RN (registered nurse). In regard to evidencing the completion of treatments, LPN #3 stated the nurses evidence treatments are done by signing the treatments off on the electronic treatment administration record.

On 9/20/23 at 10:10 a.m., an interview was conducted with RN #4, the nurse who documented the admission screener assessment and the 6/7/23 nurse's note. RN #4 stated R106 refused a skin assessment on the day of admission but per the report she received from the transferring facility, the resident did not have skin issues, so she documented no skin issues on the admission assessment. RN #4 stated the next day, she inspected R106's skin and the resident had a tremendous number of wounds. RN #4 could not remember details about the wounds but stated she documented the wounds in the clinical record. RN #4 stated that after this,

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the staff got the doctor involved because the doctor has to give orders for how to clean the wounds. (Note: RN #4 did not document a progress note regarding R106's pressure injuries until 6/7/23 and physician's orders were not obtained until 6/8/23 after the wound care physician evaluated the pressure injuries).

On 9/20/23 at 10:26 a.m., an interview was conducted with LPN #9, the nurse who documented the 5/22/23 nurse's note. LPN #9 did not remember R106 or any information about R106.

On 9/20/23 at 3:19 p.m., an interview was conducted with ASM (administrative staff member) #3 (the wound care physician). ASM #3 stated he could not provide information about R106's pressure injuries before he observed the pressure injuries. ASM #3 stated R106 was highly non-compliant with care, and he could understand why staff could have a tough time determining what treatments to use for R106's pressure injuries because of the amount of pressure injuries. ASM #3 stated he tells the staff to call him anytime and not wait until his weekly visit.

On 9/20/23 at 3:37 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concerns and the concern for harm.

On 9/21/23 at 11:28 a.m., an interview was conducted with OSM (other staff member) #7 (R106's physical therapist). OSM #7 stated he is not responsible for conducting total body skin assessments, but he completes range of motion assessments and tests residents' strength and

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mobility so if a resident complains of something unusual or pain, he checks to see the cause of limited mobility or pain. OSM #7 stated on 5/19/23, R106 complained of pain in both feet so he removed the resident's socks and saw unstageable pressure injuries that were closed, looked blackish blue but not yet eschar. OSM #7 stated he reported the pressure injuries to the nursing staff on 5/19/23.

On 9/21/23 at 12:18 p.m., a call was placed to R106's nurse practitioner but she was not available for interview.

The facility policy titled, "Pressure Injury Prevention And Management" documented, "The intent of this organization is to develop and maintain systems and processes to ensure that the resident does not develop pressure ulcers/injuries, (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to: -Promote the prevention of pressure ulcer/injury development; promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and prevent development of additional pressure ulcer/injury. SPECIFIC PROCEDURES/GUIDANCE: Risk Assessments- 1. Pressure ulcer/injury risk assessments will be conducted on admission/re-admission to the nursing facility. a. Upon admission, a risk assessment will be completed weekly for the first four weeks...3. Pressure ulcer/injury risk assessments will be conducted by a licensed/registered nurse and will be documented in the resident's medical record using the facility defined format/tool. 4. Findings from the pressure ulcer/injury risk assessment will be

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incorporated into the resident's plan of care. Preventative Measures- 1. Preventative interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences...Identification- 1. Staff will be encouraged to promptly report any observation of a change in the resident's skin integrity. 2. Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's medical record. 3. Observations of new pressure ulcer/injury will be: a. Reported to the physician/practitioner for further evaluation and treatment. b. Referred to the designated wound nurse as appropriate. Evaluation/Assessments- 1. Evaluation/assessment of pressure ulcer/injury will be completed weekly and with significant change in condition of the ulcer/injury by a licensed nurse and/or practitioner. 2. Documentation of the evaluations/assessment of the pressure ulcer/injury will [sic] maintained in the resident's medical record. Documentation may include: a. Location of ulcer/injury. b. Date that the ulcer/injury was acquired [when known]. c. Description of the ulcer/injury to include stage, measurements [length, width, depth], present/absence of any tunneling or undermining, type of tissue [epithelial, granulation, slough, necrosis, etc.], presence/absence and type of drainage, surrounding tissue description, and presence/absence of pain with the ulcer/injury. d. Treatment and interventions to promote healing...Treatment Protocols- 1. Treatments will be ordered by the physician/practitioner...3. The effectiveness of the pressure ulcer/injury treatment will be evaluated weekly during the weekly evaluation/assessment of the wound. If improvement in the wound is not seen within two

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weeks, the physician/practitioner will be contacted with the assessment and alternative treatment measures obtained as indicated...5. Treatments, including preventative interventions, will be documented in the resident's medical record...Care Plans- 1. A resident centered care plan will be developed and implemented to address the resident's risk for development of a pressure ulcer/injury and to promote healing if the resident has a pressure ulcer/injury..."

Reference:
(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear...
Stage 1 Pressure Injury: Non-blanchable erythema of intact skin.
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin....
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss.
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue)...
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration.

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Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister..."
This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

2. For Resident #108 (R108), the facility staff failed to complete thorough assessments of the resident's stage four pressure injury (1) in August 2023 and September 2023, failed to assess R108 for self-care of the pressure injury, and failed to provide oversight to ensure treatments were being completed for the pressure injury in August 2023 and September 2023.

R108 was admitted to the facility on 5/27/23 with a diagnosis of a stage four pressure injury on the sacral region. R108's comprehensive care plan dated 6/4/23 documented, "I have actual impairment to skin integrity r/t (related to) right ischium (inaccurate documentation of location). Assess/Monitor/Document wound: size, depth, margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis per facility protocols. Notify MD (medical doctor) as indicated..."

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/8/23/23, 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.

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A weekly wound evaluation dated 7/21/23 documented R108 presented with a stage four pressure injury on the right ischial (inaccurate documentation of location), present on admission, and measuring 4.5 cm (centimeters) in length by 4 cm in width by 2 cm in depth.

On 9/20/23 at 1:10 p.m., an interview was conducted with R108. R108 stated he has had a wound on his buttock for over three years. R108 stated the nurses only look at the wound when he asks, and the nurses have not measured the wound, "In a while." R108 stated he completes treatment for the wound twice a day and the treatment consists of soaking gauze in saline, putting the gauze in the wound, applying an adhesive bandage then covering that with another adhesive bandage.

A review of R108's clinical record failed to reveal thorough assessments of the pressure injury in August 2023 and September 2023. The only documentation regarding the resident's skin was a weekly skin observation dated 8/7/23 that documented no open areas, a weekly skin observation dated 8/15/23 that documented an open area on the left buttock, a weekly skin observation dated 8/21/23 regarding another skin concern but did not contain any documentation regarding the pressure injury, a weekly skin observation dated 8/29/23 that documented no open areas, and a weekly skin observation dated 9/6/23 that documented an open area on the left buttock. The weekly skin observations failed to document a description of the pressure injury (including stage, measurements, presence or absence of any tunneling or undermining, type of tissue, or presence or absence and type of drainage).

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Further review of R108's clinical record failed to reveal the resident was assessed for self-care of the pressure injury to ensure the resident was capable of caring for the pressure injury, and failed to reveal oversight was provided to ensure the resident was providing care for the pressure injury per the physician's order. A physician's order dated 6/28/23 documented to cleanse the wound to the right buttock with normal saline, apply normal saline soaked gauze to the open area, and cover with a dry adhesive dressing every shift for wound care. A review of R108's August 2023 and September 2023 TARs (treatment administration records) revealed the same physician's order but failed to reveal documentation that the treatments were completed each day for both months. The spaces for nurses to sign off the completion of the treatments were blank. Review of nurses' notes for August 2023 and September 2023 failed to reveal documentation that treatments for R108's pressure injury were completed. The only documentation of refusal of care in August 2023 and September 2023 was a nurse's note dated 8/3/23 that documented R108 declined to be seen by the wound care physician and a nurse's note dated 8/26/23 that documented R108 refused wound treatment with the wound physician.

On 9/20/23 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that after residents are admitted, weekly skin observations should be conducted on all residents and nurses are required to look at every resident's skin. LPN #3 stated assessments of pressure injuries should include a description of the wound, the measurement of

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the size, any odor, the color, the presence of drainage, and the stage if the nurse is a RN (registered nurse). In regard to evidencing the completion of treatments, LPN #3 stated the nurses evidence treatments are done by signing the treatments off on the electronic treatment administration record.

On 9/21/23 at 9:16 a.m., another interview was conducted with LPN #3. LPN #3 stated an evaluation should be completed to make sure a resident is safe and able to perform his own pressure injury care. LPN #3 stated nurses should make sure the resident has the supplies he needs for wound care, make sure the doctor is aware the resident performs his wound care, and nurses should offer assistance if needed. LPN #3 stated this should be done each time the wound care is due per the physician's order. LPN #3 stated she had not personally assessed R108's pressure injury on the buttock since June or July 2023 but she observed R108 perform wound care on the previous Monday. LPN #3 stated she observed the resident lay on his side and spread out and clean and pack the wound. LPN #3 stated she thought R108 was using a wet to dry dressing and a border gauze for his pressure injury treatment. LPN #3 stated she did not document this observation and needed to complete a late entry.

On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

Reference:
(1) "Stage 4 Pressure Injury: Full-thickness skin and tissue loss.

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Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

3. For Resident #96 (R96), the facility staff failed to complete thorough assessments of the resident's stage three pressure injury (1) in August 2023 and September 2023, and failed to provide treatments per physician's orders on multiple dates in September 2023.

R96 was admitted to the facility on 8/24/23 with a diagnosis of a stage three pressure injury of the sacral region (1). An admission evaluation dated 8/24/23 documented an open pressure area on the sacrum. A weekly skin observation note dated 8/25/23 documented R96 was admitted with an open area to the sacrum measuring 1.5 cm (centimeters) (length) by 1.5 cm (width). A weekly skin observation dated 9/4/23 documented, "Resident was admitted with an open area to sacrum (1.5cm x 1.5cm)." A weekly skin observation dated 9/11/23 documented, "Open area" and "Cleanse sacral wound with wound cleanser. Apply calcium alginate (used to treat wounds) to wound bed cover with foam dressing." A weekly skin observation dated 9/19/23 documented, "Admitted with open area to sacrum." The weekly skin observations failed to document a description of the pressure injury (including stage, measurements [8/24/23, 9/11/23 and 9/19/23], presence or absence of any tunneling or undermining, type of tissue, or presence or

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absence and type of drainage).

Further review of R96's clinical record revealed the following physician's orders:
8/24/23- clean the sacral area with normal saline and cover with form board gauze daily (discontinued 9/8/23).
9/8/23- cleanse the sacral wound with wound cleanser. Apply calcium alginate to wound bed and cover with foam dressing every day shift.
A review of R96's September 2023 TARs (treatment administration records) revealed the same physician's orders but failed to reveal documentation that the treatments were completed on 9/1/23, 9/4/23, 9/8/23, 9/10/23, 9/11/23, 9/14/23 and 9/15/23. The spaces for nurses to sign off the treatments had been done were blank. A review of nurse's notes for all dates also failed to reveal documentation that the treatments were completed.

On 9/20/23 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that after residents are admitted, weekly skin observations should be conducted on all residents and nurses are required to look at every resident's skin. LPN #3 stated assessments of pressure injuries should include a description of the wound, the measurement of the size, any odor, the color, the presence of drainage, and the stage if the nurse is a RN (registered nurse). In regard to evidencing the completion of treatments, LPN #3 stated the nurses evidence treatments are done by signing the treatments off on the electronic treatment administration record.

On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

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F 686	Continued From page 90 (the director of nursing) were made aware of the above concern. Reference: (1) "Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined the facility staff failed to implement a safe smoking environment for three out of 40 residents in the survey sample, Residents #13, #62 and #101. The findings include: 1. For Resident #13 (R13), the facility staff failed to secure smoking materials observed carried by R13 during observations on 9/19/2023.	F 689	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Facility has secured the smoking materials for Resident #13 and #101. Resident #62 has been using a cigarette extender and smoking apron while smoking. 2. An audit has been performed on all	11/3/23

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F 689	Continued From page 91 On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 6/24/2023, the resident scored 6 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. On 9/19/2023 at 2:30 p.m., an observation was made of R13 in the facility courtyard smoking. R13 was observed lighting their cigarette using a lighter that they removed from their pocket of the cargo shorts they were wearing and returning the lighter to the pocket. The supervising staff member was heard asking R13 if they needed a light for the cigarette in which R13 stated that they had one. R13 was observed returning into the facility at the end of the break with the lighter in their shorts pocket. On 9/19/2023 at 4:30 p.m., an additional observation was conducted of R13 in the facility courtyard smoking. R13 was observed smoking during the supervised smoke break using a lighter that they removed from their shorts pocket and was observed sharing the lighter with another resident to light their cigarette and returning the lighter to their shorts pocket. R13 was observed to return to the facility at the end of the break with the lighter in their shorts pocket. The supervising staff member was observed directly in front of R13 talking to the residents during the smoke break. On 9/20/2023 at 9:09 a.m., an interview was conducted with R13. R13 stated that they currently smoked. When asked about their cigarettes and lighter, R13 stated that the nurses kept everything at the desk.	F 689	current residents who smoke to ensure that all their smoking material is stored in a safe place in the facility. Any residents found to have smoking materials on their person when not smoking during scheduled smoking time will be reeducated on resident smoking policy. An audit has been performed on all current residents who have been evaluated to need adaptive/protective equipment to smoke safely to ensure that the equipment is being used. Any residents found to not be using adaptive/protective equipment will be reevaluated and/or reeducated on the need for adaptive/protective equipment to smoke. 3. The Administrator/Designee will reeducate staff on implementing a safe smoking environment. This education will include, but not be limited to, proper storage of residents smoking material and the proper use of adaptive/protective equipment while smoking. A smoking evaluation will be completed for newly identified smokers. 4. The Administrator/Designee will conduct an audit of residents smoking weekly for 4 weeks and monthly for 2 months to ensure smoking material is stored properly and adaptive/protective equipment is utilized by residents who have been assessed to need it. The Administrator/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least	

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F 689	Continued From page 92 The comprehensive care plan for R13 documented in part, "(R13) is a smoker. Date Initiated: 03/17/2023. Revision on: 08/09/2023." The clinical record documented a smoking resident safety evaluation for R13 dated 3/22/2023 which documented the resident able to smoke with supervision. On 9/19/2023 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the CNA's (certified nursing assistants) normally supervised the smoke breaks at the facility and they were filling in for the 2:30 p.m. break because they were busy. He stated that he did not think that residents were supposed to have cigarettes or lighters on them and he thought that all smoking materials were supposed to be kept in the smoking box at the nurses station that they brought out during breaks. He stated that he had asked some of the residents he observed outside at the 2:30 p.m. break why they had the cigarettes and lighters and was not sure of the process. He stated that he thought the smoking box process was new and they had it for a couple of weeks now. On 9/19/2023 at 3:45 p.m., an interview was conducted with CNA #11. CNA #11 stated that there were scheduled smoking times and the residents met in the room by the courtyard and the staff took them outside for breaks. She stated that they kept a locked box for the lighters and cigarettes and they passed out the cigarettes as the residents went out the door and then they lit them for the residents. She stated that this had been the process for the past two years she had worked there. She stated that she was aware of	F 689	quarterly. 5. The date of compliance is: 11/3/23	

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residents that did sneak in lighters and cigarettes and if they saw them, they were supposed to confiscate them because they were not allowed to keep them on their person. She stated that residents in the facility were not allowed to keep any smoking materials in their rooms.

On 9/19/2023 at 4:51 p.m., an interview was conducted with CNA #1. CNA #1 stated that residents were not supposed to have lighters or cigarettes on them and they were supposed to have all smoking materials in the smoking box that was locked at the nurses station. She stated that she was aware that some residents had lighters and they were not supposed to have them.

The facility policy "Smoking Permitted" revised 10/20/22 documented in part, "The facility will implement processes to respect the resident's right to smoke and will provide an environment for safe smoking in a manner that does not infringe on any resident's rights... Residents who desire to smoke may not keep smoking related materials [i.e. cigarettes, electronic smoking devices (e-cigarettes), refill cartridges/fluid, cigars, pipes, tobacco, lighter, lighter fluid, match, etc.] on their person when not smoking or in their room. a. For safety purposes, all smoking related materials, devices and tobacco products must be stored in a safe place in the facility, such as the nurses station...Protective equipment to promote safe smoking will be offered as appropriate based on resident assessment and the resident will be encouraged and assisted as necessary in using the protective devices..."

On 9/20/2023 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the

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director of nursing and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was obtained prior to exit.

2. For Resident #62 (R62), the facility staff failed to provide a cigarette extender and smoking apron for use while smoking.

On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 6/20/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. Section J documented no current tobacco use.

On 9/19/2023 at 2:30 p.m., an observation was made of R62 in the facility courtyard smoking. R62 was observed smoking two cigarettes during the supervised smoke break without using a cigarette extender or smoking apron.

On 9/19/2023 at 3:56 p.m., an interview was conducted with R62. R62 stated that they had smoked for years and had been smoking at the facility since admission. R62 stated that the facility stored their cigarettes and lighter in a box that they took at during the smoking times. R62 stated that they had a cigarette extender that they kept in their room and they took it outside "sometimes." R62 stated that the facility used to require them to use smoking aprons at one time but they were not required anymore.

On 9/19/2023 at 4:30 p.m., an additional observation was conducted of R62 in the facility

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courtyard smoking. R62 was observed smoking during the supervised smoke break without using a cigarette extender or smoking apron.

The comprehensive care plan for R62 documented in part, "History of smoking and current smoker
Date Initiated: 12/06/2019. Revision on: 08/09/2023." Under "Interventions" it documented in part, "Assist/ensure cigarette extender is used during designated smoke times. Date Initiated: 03/29/2022. Revision on: 01/11/2023... Provide with a smoking apron and assist to put on. Date Initiated: 02/19/2020. Revision on: 01/11/2023..."

The "Smoking-Resident Safety Evaluation" for R62 dated 2/9/2023 documented in part, "...Tobacco Utilization: 1. Does the resident use tobacco products? Yes. Does the facility allow smoking? Yes. Tobacco products utilized: Cigarettes/Cigars... Resident adaptive equipment needs: a. Smoking apron, b. Cigarette holder, c. Supervision..."

On 9/19/2023 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the CNA's (certified nursing assistants) normally supervised the smoke breaks at the facility and they were filling in for the 2:30 p.m. break because they were busy.

On 9/19/2023 at 3:45 p.m., an interview was conducted with CNA #11. CNA #11 stated that residents met in the room by the courtyard prior to going out to smoke at the scheduled times and were supposed to put on smoking aprons prior to going out if they required them. She stated that she knew which residents required smoking

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aprons because she worked with them so often. She stated that she knew that R62 had a cigarette extender that they kept in their room to bring with them. She stated that the staff should offer to apply smoking aprons to any residents who required them and if they refused report it to the nurse.

On 9/20/2023 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

3. The facility failed to implement interventions to maintain a safe smoking environment for Resident #101.

Resident #101 was admitted to the facility on 5/24/23 with diagnosis that included but were not limited to: diabetes,
left hemiplegia and, nicotine dependence.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/27/23, 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. A review of the MDS Section G-functional status coded the resident as requiring supervision for transfers and locomotion.

A review of the comprehensive care plan dated 8/9/23, which revealed, "FOCUS: The resident is a smoker.

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INTERVENTIONS: Instruct resident about the facility policy on smoking: locations, times, safety concerns. Instruct resident about smoking risks and hazards and about smoking cessation. aids that are available."

A review of the "Resident Safety Evaluation" dated 8/25/23, revealed "Smoking Safety Evaluation: Poor vision or blindness-no, Balance problems while sitting or standing-no, Total or limited ROM in arms or hands-no, Insufficient fine motor skills needed to securely hold-no, Lethargic / falls asleep easily during tasks or activities-no, Burns skin, clothing, furniture or other-no, Drops ashes on self-no, Follow the facility's policy on location and time of smoking-yes. Concerns: Unable to light a cigarette safely-no, Unable to hold a cigarette safely-no, Unable to extinguish a cigarette safely-no, Unable to use ashtray to extinguish a cigarette-no. Review and Plan: Is the resident a safe smoker? Safe to smoke with supervision."

On 9/19/23 at 2:25 PM, Resident #101 was observed leaving her room in a wheelchair, self-propelled, with a cigarette tucked in her right foot sock. Resident #101 was asked where she obtained the cigarette and she stated, it is in my sock and would not provide any further information.

An interview was conducted on 9/19/2023 at 2:50 PM with RN (registered nurse) #1. Asked to describe the smoking process, RN #1 stated, "You heard me asking the residents why they had their cigarettes and lighters. Normally the CNA's (certified nursing assistants) monitor smoking. I do not think that they are supposed to have their cigarettes and lighters." RN #1 stated, "When

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F 689	Continued From page 98 residents are admitted they have a form they are given they have to sign and the doctor has to sign about smoking. The smoking box is new, we have had it a couple of weeks. I never monitored smoking prior to them putting the box in place. We have this box for the cigarettes and lighters, not all the residents put them in here. They are supposed to and I do not believe that any resident should have their cigarettes or lighters. " On 9/19/23 at 3:55 PM, an observation was made of Resident #101 smoking. She entered the smoking area with a cigarette in her right hand and another resident was observed passing a lighter to Resident #101, who then lit her own cigarette. An interview was conducted on 9/19/23 at 4:00 PM with CNA #1. Asked to describe the smoking process, CNA #1 stated, this is a new box. It replaced the older box we had. The residents are to have their lighters and cigarettes in this box. They do not always follow the rules. The box is then kept in the locked med room behind the nurse's station. On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings. No further information was provided prior to exit.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		11/3/23

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F 692	Continued From page 99 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to monitor weights for two of 40 residents in the survey sample, Residents #53 and #16. The findings include: 1. For Resident #53 (R53), the facility staff failed to monitor weights between 6/9/2023-9/20/2023. On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 8/5/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The resident was coded as "no or unknown" for weight loss in the past 6	F 692	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #53 and #16 have a current weight documented. 2. An audit was performed to ensure all residents with an order to obtain a weight has a current weight documented. Any residents found not to have a current weight have been corrected. 3. The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) and C.N.A□s on importance of obtaining resident weights as ordered by	

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F 692	Continued From page 100 months. The nutritional at risk assessment for R53 dated 8/3/2023 documented in part, "... Annual assessment for (age and sex) LTC (long term care) female w/hx (with history) of UTI (urinary tract infection), PNA (pneumonia), HTN (hypertension), anemia, GERD, hypothyroidism, paraplegia, depression, chronic pain, BPD (bipolar disorder), DVT (deep vein thrombosis). Ht (height) 66", last wt (weight) obtained 6/2023 no significant weight change at that time; 8/2023 weight pending... No nutrition-related recommendations at this time, continue to monitor PO (by mouth) and weight change status..." The comprehensive care plan for R53 documented in part, "(R53) has the potential for alteration in nutritional status r/t (related to) multiple medical dx (diagnoses), paraplegia, MDD (major depressive disorder), bipolar disorder, GERD (gastroesophageal reflux disorder), BMI (body mass index) is obese, will eat meals brought in by family instead of facility meals at times. Date Initiated: 09/23/2021. Revision on: 06/20/2023." The weight summary for R53 failed to evidence a weight obtained after 6/9/2023. The clinical record for R53 failed to evidence documentation of refusal of weights between 6/10/2023-9/20/2023. On 9/20/2023 at 2:13 p.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that all residents were weighed at least monthly and more often if the	F 692	physician. 4. The Director of Nursing/designee will conduct an audit weekly for 4 weeks and monthly for 2 months of resident's weights to ensure they are obtained and monitored according to physician orders. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 11/3/23	

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nurses told them it was needed. She stated that if the resident refused they waited and attempted later that day and if they still refused they let the nurse know.

On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that residents weights were obtained on admission and then monthly. She stated that if a resident refused to be weighed they documented it in the nurses notes.

On 9/21/2023 at 11:14 a.m., an interview was conducted with OSM (other staff member) #5, registered dietician. OSM #5 stated that they monitored residents for changes in weight status, weight loss and/or gain. She stated that unless a resident triggered for weight loss or gain the weight was monitored monthly. She stated that if a resident refused to be weighed they should be notified but they were not sure of the policy and/or procedure at the facility.

The facility policy "Weight Assessment and Intervention" documented in part, "The interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents... 1. The nursing staff/designee will measure resident weights on admission as ordered by the physician/practitioner. a. If no weight concerns are noted weights will be measured monthly... 2. Weights will be recorded in in the resident's medical record..."

On 9/21/2023 at 1:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern.

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No further information was provided prior to exit.

2. For Resident #16 (R16), the facility staff failed to monitor weights in 4/2023, 5/2023, 6/2023, 7/2023 or 8/2023.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/7/2023, the resident was coded as no or unknown for weight loss in the past 6 months. The resident was assessed as receiving a therapeutic diet.

The physician orders for R16 documented in part, "No labs, no vitals. Continue monthly weights. Order Date: 3/3/2023."

The weight summary for R16 documented a weight of 179.0 lbs (pounds) on 3/6/2023 and a weight of 179.4 lbs on 9/6/2023. The weight summary failed to evidence weights obtained for 4/2023, 5/2023, 6/2023, 7/2023 or 8/2023.

The comprehensive care plan for R16 documented in part, "(Name of R16) is at risk for hydration/nutrition imbalance in setting of therapeutic diet, h/o (history of) obese BMI (body mass index), and multiple chronic disease states, hx (history) of lymphedema, h/o significant wt (weight) loss. Date Initiated: 11/06/2017. Revision on: 03/08/2023."

Review of the clinical record failed for R16 to evidence refusals of weights between 4/1/2023-8/31/2023.

On 9/20/2023 at 2:13 p.m., an interview was conducted with CNA (certified nursing assistant)

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F 692	Continued From page 103 #8. CNA #8 stated that all residents were weighed at least monthly and more often if the nurses told them it was needed. She stated that if the resident refused they waited and attempted later that day and if they still refused they let the nurse know. On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that residents weights were obtained on admission and then monthly. She stated that if a resident refused to be weighed they documented it in the nurses notes. On 9/21/2023 at 11:14 a.m., an interview was conducted with OSM (other staff member) #5, registered dietician. OSM #5 stated that they monitored residents for changes in weight status, weight loss and/or gain. She stated that unless a resident triggered for weight loss or gain the weight was monitored monthly. She stated that if a resident refused to be weighed they should be notified but they were not sure of the policy and/or procedure at the facility. On 9/21/2023 at 1:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 692		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		11/3/23

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F 695	Continued From page 104 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 provide respiratory care and services for two of 40 residents in the survey sample, Residents #270 and #48. The findings include: 1. For Resident #270 (R270), the facility staff failed to obtain physician's orders for the care of the resident's laryngectomy tube (1), failed to assess R270 for self-care of the laryngectomy tube, and failed to provide oversight to ensure the resident's care of the laryngectomy tube. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/17/23, 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. A review of R270's clinical record failed to reveal physician's orders for the care of the resident's laryngectomy tube. R270's comprehensive care plan revised on 9/1/23 failed to reveal documentation regarding the resident's laryngectomy tube. Further review of R270's clinical record from the resident's readmission on 8/14/23, failed to reveal the resident was	F 695	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #270 is no longer residing at the facility. Resident #48 does not have a physician order for an incentive spirometer, and it has been removed from his room. 2. An audit was performed to identify all residents with a laryngectomy tube to ensure a physician□s order for the care of the laryngectomy tube has been obtained, assess if resident can self-care and oversight of the resident□s care of the laryngectomy tube is being completed. An audit was performed to identify residents using an incentive spirometer to ensure a physician□s order was obtained and the incentive spirometer is being stored in a sanitary manner. Any discrepancies were immediately corrected. 3. The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding laryngectomy tubes and incentive spirometers. The in-service includes, but is not limited to, the	

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F 695	Continued From page 105 assessed for self-care of the laryngectomy tube, and failed to reveal oversight was provided to ensure the resident was performing care of the laryngectomy tube (except for 9/8/23 and 9/9/23). On 9/20/23 at 8:34 a.m., R270 was observed sitting on the bed and the resident was observed to have a laryngectomy tube. At this time, an interview was conducted with R270. The resident was unable to verbally communicate but communicated via non-verbal gestures and by writing on a communication board. R270 was asked if the nurses clean and provide care for his laryngectomy tube. The resident nodded his head side to side indicating, "No" and pointed to himself. When asked if he provides the care, R270 nodded his head up and down indicating, "Yes." When asked if the nurses check to make sure he is cleaning and caring for his laryngectomy tube, R270 nodded his head side to side, indicating, "No." R270 pointed to his supply of neck bands and wrote on his communication board that he needed more neck bands and a brush to clean the tube. On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated an evaluation should be completed to make sure a resident is safe and able to perform his own trach/laryngectomy tube care. LPN #3 stated the nurses can provide assisted to R270, but the resident really takes care of his laryngectomy tube. LPN #3 stated the resident will let staff know when he needs supplies and the nurses should offer assistance, document that assistance was offered, document that supplies were provided, and document if R270 accepts or declines assistance. LPN #3 stated this should occur at least once a day or per whatever the	F 695	importance of obtaining physician orders for laryngectomy tubes and spirometers, the need to evaluate resident to assess if they are able to self-care laryngectomy tubes and storing an incentive spirometer in a sanitary manner. 4. The Director of Nursing/designee will conduct an audit weekly for 4 weeks and monthly for 2 months of residents with laryngectomy tubes to ensure physician□s order for the care of the laryngectomy tube has been obtained, assess if resident can self-care and oversight of the resident□s care of the laryngectomy tube is being completed. The Director of Nursing/designee will conduct an audit weekly for 4 weeks and monthly for 2 months of residents with incentive spirometers to ensure a physician□s order was obtained and the incentive spirometer is being stored in a sanitary manner. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 11/3/23	

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physician's order says. LPN #3 stated that if there is no physician's order then the nurses need to call the doctor and get an order.

On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Self-Administration of Medications and Treatments" documented, "POLICY: Residents have the right to self-administer medications / treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.
SPECIFIC PROCEDURES / GUIDANCE
1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities and choice to determine whether self-administering medications and/or treatments is clinically appropriate for the resident.
2. The staff and practitioner may ask residents who are identified as being able to self-administer medications/treatments whether they wish to do so.
3. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, which may include (but not limited to) the resident's:
a. Ability to read and understand medication labels / treatment instructions;
b. Comprehension of the purpose and proper administration for his or her medications/treatments.
c. Ability to remove medications and/or treatment supplies from a container

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 107	F 695		

d. Ability to recognize risks and major adverse consequences of his or her medications/treatments.
4. If the team determines that a resident cannot safely self-administer medications/treatments, the nursing staff will administer the resident's medications.
5. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications/treatments.
6. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting those medications were taken and/or that treatments were administered...
12. Nursing staff will review the self-administered medication/treatment record on each nursing shift, and they will transfer pertinent information to the medication/treatment administration record (MAR/TAR) appropriately noting that the doses were self-administered..."

Reference:
(1) A laryngectomy tube is used after the removal of the larynx (the voice box in the throat). This information was obtained from the website: https://medlineplus.gov/ency/article/007398.htm

2. For Resident #48 (R48), the facility staff failed to obtain a physician's order for the use of an incentive spirometer and failed to store the incentive spirometer in a sanitary manner.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/28/23, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions.

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	495283	A. BUILDING _____ B. WING _____	C 09/21/2023

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F 695	Continued From page 108 A review of R48's clinical record failed to reveal a physician's order for an incentive spirometer. R48's care plan dated 9/19/23 failed to document information regarding an incentive spirometer. On 9/19/23 at 11:34 a.m., R48 was observed sitting in a wheelchair in the bedroom. An incentive spirometer was observed sitting on the resident's overbed table. The incentive spirometer was uncovered, and the mouthpiece was exposed to air. On 9/21/23 at 8:19 a.m., R48 was observed sitting in a wheelchair in the bedroom. The incentive spirometer was observed sitting on the bed, uncovered, with the mouthpiece exposed to air. At this time, an interview was conducted with R48. The resident stated he uses the incentive spirometer once or twice a day and staff had not provided a bag or cover for the device. On 9/21/23 at 9:16 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated residents should have a physician's order for the use of an incentive spirometer because everything has to have a doctor's order. LPN #3 stated an incentive spirometer should be stored in a little baggie for infection control purposes. On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l)	F 698		11/3/23

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F 698	Continued From page 109 §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 two of 40 residents in the survey sample, Resident #119 and Resident #83. The findings include: 1. For Resident #119, the facility failed to provide a bagged lunch to take to the dialysis appointments for four of four days and to failed to communicate with the dialysis facility for three of four days. Resident #119 was admitted to the facility on 9/9/23 with diagnosis that included but were not limited to: ESRD (end stage renal disease), dialysis and acute pancreatitis. The most recent MDS (minimum data set) assessment, an uncompleted Medicare 5-day assessment, with an ARD (assessment reference date) of 9/16/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-was incomplete. Section O- Special Procedures/Treatments was incomplete. A review of the physician's order dated 9/12/23	F 698	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #119 is no longer residing at the facility. Resident #83 has a dialysis communication book that reflects communication and collaboration with the resident□s hemodialysis center. 2. An audit has been performed on all residents receiving dialysis care to ensure bagged nutrition is sent with the resident to dialysis and that they have a dialysis communication book that reflects communication and collaboration with the resident□s hemodialysis center. Any discrepancies have been corrected. 3. The Food Service Director will reeducate Cooks and Dietary Aides on the importance of providing nutrition to dialysis residents prior to them leaving for dialysis. The Director of Nursing/Designee will reeducate LPNs, and RNs on the importance of the communication process between the facility and the dialysis center. This education will include, but not be limited to, the dialysis residents having	

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revealed, "Dialysis every T-TH-SA."

A review of Resident #119's dialysis communication book revealed a communication sheet for 9/12/23, however there were no communication sheets for 9/14/23, 9/16/23 and 9/19/23.

An interview was conducted on 9/20/23 at 8:40 AM with Resident #119 and when asked what items he took with him to dialysis, Resident #119 stated, there was nothing. When asked if he takes a bagged meal or a communication binder, Resident #119 stated, "No, there is no bagged lunch and I do not have binder."

An interview was conducted on 9/20/23 at 8:00 AM with RN #2. When asked the purpose of the dialysis communication form, RN #2 stated, the purpose is to share and receive information with the dialysis center, including vital signs, medications any lab results. When asked to review Resident #119's dialysis communication book, RN #2 stated, there is a form for 9/12/23, but he should have had one for 9/14/23, 9/16/23 and 9/19/23. He is missing three forms. When asked if Resident #119 took a bagged lunch with him, RN #2 stated, "That is what I am used to at other places, but there is no bagged lunch for him here. He leaves early in the morning."

An interview was conducted on 9/20/23 at 11:20 AM with OSM (other staff member) #1, the dietary director. When asked if residents are provided a bagged lunch to take to dialysis, OSM #1 stated yes, they are. When asked to describe the process of dietary being notified of a resident needing the bagged lunch, OSM #1 stated, "There is usually a renal diet and then nursing

a dialysis communication book that is to be sent with them to the dialysis center.

4. The Food Service Director will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure nutrition is sent with the resident to dialysis. The Director of Nursing/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure that residents have a dialysis communication book sent to dialysis center and that it reflects communication and collaboration with the resident□s hemodialysis center. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.

5. The date of compliance is: 11/3/23

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lets us know the dialysis schedule and time. For instance, if the resident leaves early in the morning, we make sure the bagged lunch is sent on the Resident's supper tray so it can be put in the refrigerator. If they leave mid-morning, then we send the bagged lunch on the breakfast tray. We do not have this resident on our list as a dialysis resident." When asked to review if Resident #119 is being sent a bagged lunch, OSM #1 stated, no he is not and they have not been notified that he is a dialysis resident and the days and times of dialysis.

On 9/20/23 at 3:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the findings.

A review of the facility's "End Stage Renal Disease-Care of the Patient" policy, revealed, "Agreements between this facility and the contracted ESRD facility will include all aspects of how the resident's care will be managed including but not limited to:
a. the development of a comprehensive and integrated care plan
b. the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination, and collaboration.
c. timely medication administration
d. advance directives and code status
e. nutritional and fluid management
f. provision and documentation of appropriate access care
g. hemodialysis treatment days and times

No further information was provided prior to exit.

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2. For Resident #83 (R83), the facility staff failed to ensure adequate communication and collaboration for care with the resident's hemodialysis center.

A review of R83's clinical record revealed a physician's order dated 6/5/23 for dialysis every Monday, Wednesday, and Friday at 11:45 a.m.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/9/23, 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.

Further review of R83's clinical record failed to reveal communication and collaboration with the hemodialysis center except for a dietary note dated 6/28/23 that documented R83 was to be placed on a fluid restriction, and nurses' notes dated 7/17/23 and 9/11/23 that documented the dialysis center was called to inform staff that R83 refused to go to dialysis those days.

On 9/19/23 at 3:58 p.m., observation of the nurse's station failed to reveal a dialysis communication folder/book for R83. An employee stated the book was probably in R83's room. At that time, an observation of R83's room was conducted. No dialysis communication folder/book was observed and R83 stated she had never been provided a dialysis communication book.

On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that usually a resident who receives dialysis has a folder with his or her name

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F 698	Continued From page 113 on it and the nurses are responsible for sending a communication sheet to the dialysis facility each time the resident goes to dialysis. LPN #3 stated the dialysis communication sheet contains information such as the resident's vital signs, documentation about anything that has changed since the last treatment, any recent labs, any changes in the resident's diet, and documentation about the resident's dialysis access. On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 698		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to ensure there was an RN (registered nurse) on duty for eight consecutive hours on 9/16/20223.	F 727	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements.	11/3/23

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F 727	Continued From page 114 The findings include: A review of the last 30 days as-worked schedule was conducted. There was no evidence that an RN was on duty for eight consecutive hours on 9/16/23. The Nursing Staffing Data for 9/16/2023 had blanks in the spaces for the number of RNs for each shift on 9/16/2023. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/20/2023 at 10:25 a.m. When asked the process for ensuring an RN is on duty for eight hours each day, ASM #2 stated the facility usually has RNs on duty as they have both full time and part time RNs. ASM #2 explained that on that day, they had two agency RNs scheduled and they canceled their shifts around 6:00 a.m. She stated she couldn't get coverage. When asked should there be an RN on duty for at least eight consecutive hours each day, ASM #2 stated, yes. A request was made for the policy regarding RN coverage. On 9/20/23 at 11:21 a.m., ASM #1, the administrator, stated that they did not have a policy, they just follow the regulations. ASM #1 and ASM #2 were made aware of the above concerns on 9/20/2023 at 10:25 a.m.	F 727	1. There has been an RN on duty for eight consecutive hours since 9/17/23. 2. An audit has been performed of the as-worked schedule since 9/17/23. There has been an RN on duty for eight consecutive hours since 9/17/23. 3. The Director of Nursing/Designee will reeducate Scheduler on the importance of ensuring there is a RN on duty for eight consecutive hours each day. 4. The Director of Nursing/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure there is a RN on duty for eight consecutive hours each day. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		11/3/23

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F 732	Continued From page 115 §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 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility	F 732	This plan of correction is respectfully submitted, and it is an affirmation that	

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F 732	Continued From page 116 staff failed to post the nurse staffing information on 9/20/2023. The findings include: On 9/20/2023 at 10:29 a.m. an observation of the receptionist desk was conducted. On the desk was the staffing posting, however the paper in the frame was dated 9/19/2023. An interview was conducted with OSM (other staff member) #2, the receptionist, on 9/20/2023 at 10:31 a.m. When asked who is responsible for putting up the staff posting each day, OSM #2 stated the scheduler usually does it. OSM #2 was asked if the scheduler isn't here, then who puts it up, OSM #2 stated the DON (director of nursing) does it. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/20/2023 at 10:32 a.m. When asked who is responsible for posting the staff posting for each day, ASM #2 stated the scheduler was out today and that she is the back up and she didn't do it. The facility policy, "Posting Direct Care Daily Staffing" documented in part, "Policy: Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Specific Procedures/Guidance: 1. At the beginning of each shift, the number of licensed nurses (RNs -registered nurses, LPNs - licensed practical nurses) and the number of unlicensed nursing personnel (CNAs -certified nursing assistants) directly responsible for resident care will be posted in a prominent location (accessible to	F 732	corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. The Direct Care Staffing posting was corrected immediately on 9/20/23. 2. The Direct Care Staffing has been posted each day since 9/20/23. 3. The Administrator will reeducate the Scheduler, Receptionist and Management team on the importance of posting the direct care staffing information each day. 4. The Administrator will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure the direct care staffing is posted. The Administrator will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 732	Continued From page 117 resident and visitors) and in a clear and readable format." ASM #1, the administrator and ASM #2 were made aware of the above finding on 9/20/2023 at 10:35 a.m. No further information was provided prior to exit.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		11/3/23

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F 755	Continued From page 118 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide pharmacy services for one of 40 residents in the survey sample, Resident #96. The findings include: For Resident #96 (R96), the facility staff failed to ensure the medication Nubeqa (1) was available for administration on multiple dates in August 2023. A review of R96's clinical record revealed a physician's order dated 8/24/23 for Nubeqa 300 mg (milligrams)- two tablets by mouth two times a day for prostate cancer. A review of R96's August 2023 MAR (medication administration record) revealed the same physician's order for Nubeqa. On 8/26/23 (a.m. and p.m. doses), 8/27/23 (a.m. and p.m. doses), 8/28/23 (p.m. dose), 8/29/23 (p.m. dose), 8/30/23 (p.m. dose) and 8/31/23 (a.m. dose), the MAR documented the code, "9=Other / See Nurse Notes" Nurses' notes dated 8/26/23 documented, "Will administer when med arrive from pharmacy" and "Medication out of stock, resident made aware, will continue to monitor." Nurses' notes dated 8/27/23 documented, "Will administer when med arrive from pharmacy" and "Awaiting delivery from pharmacy." A nurse's note dated 8/28/23 documented, "Medication not in stock, reorder on 8/24/23." A nurse's note	F 755	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Residents #96 no longer resides at the facility. 2. A MAR to Cart audit has been completed for all current medication carts. Any missing Medications are now available. 3. The Director of Nursing/Designee will reeducate LPNs, and RNs on the importance of following general guidelines for medication administration. This education will include, but not be limited to, the steps to take when a medication is not available. 4. The Director of Nursing/Designee will perform an audit on 25% of residents weekly for 4 weeks and then monthly for 2 months to ensure medication with a current, active order is available to be administered. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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	495283	A. BUILDING _____ B. WING _____	C 09/21/2023

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F 755	Continued From page 119	F 755		

dated 8/29/23 documented, "Medication reordered as currently unavailable [sic]." A nurse's note dated 8/30/23 documented, "On order from pharmacy." A nurse's note dated 8/31/23 documented, "Will administer when med arrive from pharmacy." A nurse's note dated 9/1/23 documented, "Writer called pharmacy in regards to Nubeqa tablet. Pharmacy informed writer medication comes from a special pharmacy. MD (Medical Doctor) made aware with new orders noted: Okay to receive medication from resident family. Writer call [sic] resident RP (Responsible Party) who will bring medication to nursing staff 9/2/23."

A review of the facility backup medication supply list revealed Nubeqa was not available in the supply.

On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that if a medication is not available for administration, the nurses are supposed to notify the doctor and see what he recommends, call the pharmacy to let them know the medication is not at the facility, see how long it will be before the medication arrives, then notify the resident's family and make them aware the medication is not available. LPN #3 stated this should be done each time a medication is not available, and this should be documented in the clinical record.

On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility pharmacy policy title, "General

5. The date of compliance is: 11/3/23

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F 755	Continued From page 120 Guidelines for Medication Administration" documented, "If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit." Reference: (1) "Darolutamide (Nubeqa) is used to treat certain types of prostate cancer...Do not stop taking darolutamide without talking to your doctor." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a619045.html	F 755		
F 758 SS=E	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	F 758		11/3/23

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F 758	Continued From page 121 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 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 staff interview, facility document review and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary psychotropic medication for one of 40 residents in the survey sample, Resident #83. The findings include:	F 758	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #83 has been evaluated by the physician/nurse practitioner to	

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F 758	Continued From page 122 For Resident #83 (R83), the facility staff failed to ensure the physician or nurse practitioner evaluated the resident for continued use of the as needed anti-anxiety medication diazepam (1). A review of R83's clinical record revealed a physician's order dated 8/4/23 for diazepam 5 mg (milligrams)- one tablet by mouth every eight hours as needed for 180 days for anxiety. A review of R83's August 2023 and September 2023 MARs (medication administration records) revealed the resident was administered as needed diazepam 28 times in August 2023 and 24 times in September 2023. Further review of R83's clinical record failed to reveal the physician or nurse practitioner documented a rationale for extended use and failed to reveal the physician or nurse practitioner evaluated the resident for continued use of the medication after the medication had been administered for 14 days. On 9/21/23 at approximately 12:20 p.m., a call was placed to R83's nurse practitioner. She was not available for interview. On 9/21/23 at 1:26 p.m., an interview was conducted with ASM (administrative staff member) #1 (the director of nursing). ASM #1 stated the standard prescription for as needed anti-anxiety medications is for 14 days then the doctor decides if he or she wants to continue the medication or not. On 9/21/23 at 1:28 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Antipsychotic Medication Use" documented, "14. The need to continue	F 758	determine use of the anti-anxiety medication, diazepam. 2. An audit has been performed on all residents with physician orders for anti-anxiety medications to ensure the physician/nurse practitioner has evaluated the resident for continued use of the anti-anxiety medication after being administered for 14 days and if needed, there is documented rationale for extended use of the medication. Any discrepancies have been corrected. 3. The Director of Nursing/Designee will reeducate Physicians and Nurse Practitioners on the importance of evaluating residents for continued use of the anti-anxiety medication after medication has been administered for 14 days. This education will include, but not be limited to, documenting a rationale for extended use of the medication. 4. The Director of Nursing/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure the physician/nurse practitioner has evaluated the resident for continued use of the anti-anxiety medication after being administered for 14 days and if needed, there is documented rationale for extended use of the medication. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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F 758	Continued From page 123 PRN (as needed) orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order." Reference: (1) Diazepam is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682047.html	F 758	5. The date of compliance is: 11/3/23	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a medication error rate of less than 5% for one of 40 residents in the survey sample; Resident #219. During the Medication Administration task, out of 29 opportunities, the facility failed to administer four medications, resulting in an error rate of 13.79%. The findings include: For Resident #219 the facility failed to administer four medications during the medication administration task. On 9/20/23 at 9:05 AM, the medication administration was conducted with LPN #10	F 759	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #219□s physician and RP was notified of medication errors. Resident had no adverse reaction as a result of medication errors. 2. A medication pass audit has been performed on LPNs and RNs to ensure the medication error rate is less than 5%. Any discrepancies have been corrected. 3. The Director of Nursing/Designee will reeducate LPNs and RNs on medication	11/3/23

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F 759	Continued From page 124 (Licensed Practical Nurse), for Resident #219. Upon review of the physician's orders (below) and the Medication Administration Record (MAR) for September 2023 revealed that four medications were ordered but were not prepared and administered on observation. They were signed out as being administered. A review of the physician's orders revealed the following: (1) Aspirin an 81 mg (milligrams) tablet once daily. Order dated 9/8/23. (2) Valsartan an 80 mg tablet once daily. Order dated 9/8/23. (3) Vitamin D3 a 25 mcg (micrograms) tablet. Give two tablets once daily. Order dated 9/9/23. (4) Zinc a 220 mg tablet once daily for wound healing. Order dated 9/13/23. On 9/20/23 at 1:10 PM, an interview was conducted with LPN #10. She stated that she thought she pulled and administered the above medications, and is why they were signed out as being administered. She stated that she did not know how she missed them. On 9/20/23 at 1:50 PM, a second follow up interview was conducted with LPN #10. She stated that the process for medication administration included the five rights of making sure you have the right dose, right time, right route, right resident and the right medication. She stated that since there were medications that were missed, the five rights were not followed. The facility policy "Adverse Consequences and Medication Errors" documented, "...."Medication Error" is defined as the preparation or	F 759	administration. This education will include, but not limited to, adverse consequences of medication errors. 4. The Director of Nursing/Designee will perform a medication pass audit weekly for 4 weeks and then monthly for 2 months to ensure the medication error rate is less than 5%. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 759	Continued From page 125	F 759		

administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services....5. Examples of medications errors include: a. omission - a drug is ordered but not administered; b. unauthorized drug - a drug is administered without a physician's order; c. wrong dose... d. wrong route of administration... e. wrong dosage form... f. wrong drug... g. wrong time; and/or; h. failure to follow manufacturer instructions and/or accepted professional standards..."

On 9/20/23 at 3:30 PM, an end-of-day meeting was conducted with ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #4, the Regional Nurse Consultant, were made aware of the findings. No further information was provided by the end of the survey.

References:
(1) Aspirin - Is used to prevent heart attacks, strokes, and reduce the risk of death from a heart attack or stroke.
Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html

(2) Valsartan - Is used alone or in combination with other medications to treat high blood pressure.
Information obtained from https://medlineplus.gov/druginfo/meds/a697015.html

(3) Vitamin D3 - Is used as a dietary supplement when the amount of vitamin D in the diet is not

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F 759	Continued From page 126 enough...is also used along with calcium to prevent and treat bone diseases... Information obtained from https://medlineplus.gov/druginfo/meds/a620058.html (4) Zinc - Is an essential trace element commonly found in red meat, poultry, and fish. It is necessary in small amounts for human health, growth, and sense of taste. Zinc is found throughout the body. The body doesn't store excess zinc, so it must be obtained from the diet. It's needed for immune function, wound healing, blood clotting, thyroid function, and much more. It also plays a key role in maintaining vision and might have effects against viruses. Information obtained from https://medlineplus.gov/druginfo/natural/982.html)	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a resident was free of a significant medication error for one of 40 residents in the survey sample, Resident #96. The findings include: For Resident #96 (R96), the facility staff failed to administer the medication Nubeqa (1), used to treat prostate cancer, on multiple dates in August 2023.	F 760	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Residents #96 no longer resides at the facility. 2. A MAR to Cart audit has been completed for all current medication carts. Any missing Medications are now	11/3/23

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F 760	Continued From page 127 A review of R96's clinical record revealed a physician's order dated 8/24/23 for Nubeqa 300 mg (milligrams)- two tablets by mouth two times a day for prostate cancer. A review of R96's August 2023 MAR (medication administration record) revealed the same physician's order for Nubeqa. On 8/26/23 (a.m. and p.m. doses), 8/27/23 (a.m. and p.m. doses), 8/28/23 (p.m. dose), 8/29/23 (p.m. dose), 8/30/23 (p.m. dose) and 8/31/23 (a.m. dose), the MAR documented the code, "9=Other / See Nurse Notes" Nurses' notes dated 8/26/23 documented, "Will administer when med arrive from pharmacy" and "Medication out of stock, resident made aware, will continue to monitor." Nurses' notes dated 8/27/23 documented, "Will administer when med arrive from pharmacy" and "Awaiting delivery from pharmacy." A nurse's note dated 8/28/23 documented, "Medication not in stock, reorder on 8/24/23." A nurse's note dated 8/29/23 documented, "Medication reordered as currently unavailable [sic]." A nurse's note dated 8/30/23 documented, "On order from pharmacy." A nurse's note dated 8/31/23 documented, "Will administer when med arrive from pharmacy." A nurse's note dated 9/1/23 documented, "Writer called pharmacy in regards to Nubeqa tablet. Pharmacy informed writer medication comes from a special pharmacy. MD (Medical Doctor) made aware with new orders noted: Okay to receive medication from resident family. Writer call [sic] resident RP (Responsible Party) who will bring medication to nursing staff 9/2/23." On 9/21/23 at approximately 12:20 p.m., a call was placed to R83's nurse practitioner. She was not available for interview.	F 760	available. 3. The Director of Nursing/Designee will reeducate LPNs, and RNs on the importance of following general guidelines for medication administration. This education will include, but not be limited to, the steps to take when a medication is not available and the importance of residents being free of significant med errors. 4. The Director of Nursing/Designee will perform an audit on 25% of residents weekly for 4 weeks and then monthly for 2 months to ensure medications with a current, active order are available to be administered. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 760	Continued From page 128 On 9/21/23 at 12:58 p.m., an interview was conducted with OSM (other staff member) #8 (the quality assurance pharmacist). OSM #8 stated that based on the manufacturer's package information, Nubeqa is usually used for prostate cancer. In regard to the importance of a resident receiving Nubeqa as prescribed, OSM #8 stated that this was patient specific and depended on what other medications the resident was receiving but, "Generally chemotherapy is not something you want to miss as a general rule." On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Adverse Consequences and Medication Errors" documented, "5. Examples of medications errors include: a. omission-a drug is ordered but not administered..." Reference: (1) According to the Nubeqa manufacturer's website, Nubeqa is used to treat prostate cancer. The website further documented, "TAKE NUBEQA EXACTLY AS YOUR DOCTOR TELLS YOU." https://www.nubeqa-us.com/what-is-nubeqa#taking-nubeqa	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality	F 770		11/3/23

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F 770	Continued From page 129 and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to obtain ordered laboratory testing for one of 40 residents in the survey sample, Resident #53. The findings include: For Resident #53 (R53), the facility staff failed to obtain a stool culture as ordered on 9/14/2023. On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 8/5/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. On 9/19/2023 at 12:04 p.m., an interview was conducted with R53. R53 stated that they had been sick off and on for about 16 days with heartburn, nausea and abdominal pain. R53 stated that they had an x-ray done and had seen the doctor once and the nurse practitioner a couple of times. R53 stated that they were concerned that they were being brushed off because they still had times when they felt bad and didn't know what the next step was. The physician orders for R53 documented in part,	F 770	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #53□s physician discharged order for stool culture. 2. An audit has been performed on all residents with current physician orders for laboratory services to ensure the laboratory testing has been obtained. Any discrepancies have been corrected. 3. The Director of Nursing/Designee will reeducate LPNs and RNs on the importance of obtaining laboratory testing ordered by the physician. This education will include, but not be limited to, the importance of notifying the physician and/or the nurse practitioner if the laboratory test is not obtained. 4. The Director of Nursing/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure laboratory testing ordered by the physician is obtained. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance	

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F 770	Continued From page 130 "Obtain stool culture one time only for c-diff (1) for 2 days. Order Date: 09/14/2023." The eTAR (electronic treatment administration record) for R53 dated 9/1/2023-9/30/2023 failed to evidence collection of the stool specimen ordered on 9/14/2023. The progress notes documented in part, "9/14/2023 14:10 (2:10 p.m.) Physician/NP progress note. Member c/o (complains of) abdominal pain and 2 loose stools. NP (nurse practitioner) ordered stool culture and KUB (x-ray). NP encouraged member to take medications as prescribed member verbalized understanding." The clinical record failed to evidence documentation of the stool culture being obtained or sent to the lab. The clinical record further failed to evidence documentation of notification of the physician and/or the nurse practitioner of the stool specimen not being collected. On 9/21/2023 at 9:07 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they had looked for the results of the ordered stool culture and did not find anything and they were going to follow up with the other nurses and the nurse practitioner. On 9/21/2023 at 11:07 a.m., LPN #3 stated that they had spoken with the nurse practitioner and she had canceled the order for the stool culture due to the resident no longer having any diarrhea. She stated that the order was canceled 9/21/2023 and she would have expected nursing to have addressed the stool culture not having been obtained prior to today.	F 770	Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 770	Continued From page 131 On 9/21/2023 at 11:41 a.m., an interview was conducted with ASM (administrative staff member) #5, nurse practitioner. ASM #5 stated that they had examined R53 last on 9/15/2023 and reviewed the x-ray results with them then. She stated that she had examined them prior to that for complaints of abdominal pain and diarrhea when she had ordered an x-ray and stool culture. She stated that as of the last examination R53 had not complained of any pain and had not reported any new concerns to the staff. The facility policy, "Lab and Diagnostic Test Results" documented in part, "...1. The physician/practitioner will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests as ordered..." On 9/21/2023 at 1:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 770		
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	F 840		11/3/23

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F 840	Continued From page 132 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 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 and facility document review, it was determined the facility staff failed to have a written dialysis agreement for two of 40 residents in the survey sample, Resident #119 and #83. The findings include: 1. For Resident #119, the facility failed to evidence a written dialysis agreement with a dialysis center, . Resident #119 was admitted to the facility on 9/9/23 with diagnosis that included but were not limited to: ESRD (end stage renal disease), and dialysis. A review of the comprehensive care plan dated 9/9/23 which revealed, "FOCUS: The resident has ESRD and receives Hemodialysis on Tuesday/Thursday/Saturday (T-TH-SA). INTERVENTIONS: Pre-Post dialysis weights. Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per	F 840	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #119 no longer resides at the facility. A dialysis agreement with Resident #83□s dialysis center has been obtained. 2. An audit has been performed on all residents receiving dialysis services to ensure the facility has a dialysis agreement with each of the resident□s dialysis centers. Any discrepancies have been corrected. 3. The Regional Director of Operations will reeducate the Administrator on the importance of having written dialysis agreements with resident□s dialysis centers. 4. The Regional Director of	

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F 840	Continued From page 133 protocols." A review of the physician's order dated 9/12/23 revealed, "Dialysis every T-TH-SA." During the entrance conference to the facility on 9/19/23, a request was made for the dialysis contracts or agreements. On 9/20/23 at 12:37 PM, ASM (administrative staff member) #1, the administrator, stated, "We do not have the dialysis contract and we have been working with them to get us one. We have the old contract from the previous company but do not have one for the dialysis centers under our corporation." When asked the effective date of the new corporation, ASM #1 stated it was 12/19/22. On 9/20/23 at 3:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the findings. A review of the facility's "End Stage Renal Disease-Care of the Patient" policy, revealed, "Agreements between this facility and the contracted ESRD facility will include all aspects of how the resident's care will be managed including but not limited to: a. the development of a comprehensive and integrated care plan b. the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination, and collaboration. c. timely medication administration d. advance directives and code status	F 840	Operations/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure written dialysis agreements with resident□s dialysis centers are in place. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 840	Continued From page 134	F 840		

e. nutritional and fluid management
f. provision and documentation of appropriate access care
g. hemodialysis treatment days and times

No further information was provided prior to exit.

2. For Resident #83, the facility failed to evidence a written dialysis agreement with a dialysis center.

Resident #83 was admitted to the facility on 6/3/23 with diagnosis that included but were not limited to: ESRD (end stage renal disease), and dialysis.

A review of the comprehensive care plan dated 9/9/23 which revealed, "FOCUS: The resident has ESRD and receives Hemodialysis on (M,W,F). INTERVENTIONS: Pre-Post dialysis weights. Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols."

A review of the physician's order dated 6/5/23 revealed, "Dialysis every Monday, Wednesday, and Friday at 11:45 AM."
During the entrance conference to the facility on 9/19/23, a request was made for the dialysis contracts or agreements to be provided.

On 9/20/23 at 12:37 PM, ASM (administrative staff member) #1, the administrator, stated, "We do not have the dialysis contract and we have been working with them to get us one. We have the old contract from the previous company but do not have one for the dialysis centers under our corporation." When asked the effective date of the new corporation, ASM #1 stated it was

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F 840	Continued From page 135 12/19/22. On 9/20/23 at 3:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the findings. No further information was provided prior to exit.	F 840		
F 842 SS=E	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;	F 842		11/3/23

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F 842	Continued From page 136 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening 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:	F 842		

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F 842	Continued From page 137 Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to maintain an accurate clinical record for one of 40 residents in the survey sample, Resident #108. The findings include: For Resident #108 (R108), the facility staff failed to accurately document the location of the resident's pressure injury on multiple weekly wound evaluations and the resident's care plan. R108 presented with a pressure injury on the sacrum (1)/buttock but the wound evaluations and care plan documented the pressure injury was on the right ischial/ischium (2). R108 was admitted to the facility on 5/27/23 with a diagnosis of a stage four pressure injury (3) on the sacral region. A weekly wound evaluation dated 6/2/23 documented R108's pressure injury was located on the right ischium. R108's comprehensive care plan dated 6/4/23 documented, "I have actual impairment to skin integrity r/t (related to) right ischium..." Weekly wound evaluations dated 6/9/23, 6/16/23, 6/23/23, 6/30/23, and 7/7/23 documented the pressure injury was located on the right ischial. A physician's order dated 6/28/23 documented to cleanse the wound to the right buttock with normal saline, apply normal saline soaked gauze to the open area, and cover with a dry adhesive dressing every shift for wound care. A physician's note dated 9/11/23 documented R108 was admitted with a sacral wound. On 9/20/23 at 1:10 p.m., an interview was	F 842	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #108□s medical record has been updated to reflect resident□s pressure injury is on his sacral region. The update includes a clarification note and care plan revision. 2. An audit has been performed on all residents with pressure injuries to ensure accurate documentation of the location of the pressure injury on their care plans and wound evaluations. Any discrepancies have been corrected. 3. The Director of Nursing/Designee will reeducate Administrative Nurses, LPNs and RNs on the importance of maintaining accurate clinical records. This education will include, but not be limited to, ensuring the location of a resident□s pressure injury is documented accurately on wound evaluations and care plans. 4. The Director of Nursing/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure the location of resident's pressure injuries are accurately documented on their wound evaluations and care plans. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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F 842	Continued From page 138 conducted with R108. R108 stated he has had a wound on his buttock for over three years. On 9/21/23 at 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who documented the weekly wound evaluations). LPN #3 stated R108's pressure injury was located on his buttock. On 9/21/23 at 1:28 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Pressure Injury Prevention and Management" documented, "2. Documentation of the evaluations/assessment of the pressure ulcer/injury will [sic] maintained in the resident's medical record. Documentation may include: a. Location of ulcer/injury." References: (1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm (2) The ischium is the lower and back part of the hip bone. This information was obtained from the website: https://medlineplus.gov/appendixa.html (3) "Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resm	F 842	5. The date of compliance is: 11/3/23	

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F 842	Continued From page 139 gr/online_store/npiap_pressure_injury_stages.pdf	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		11/3/23

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F 880	Continued From page 140 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to follow infection control practices for two of 40 residents in the survey sample, Resident #49 and #120. The findings include:	F 880	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #120 no longer resides at the facility. Resident #49□s bi-pap mask has	

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F 880	Continued From page 141 1. Resident #49's bi-pap mask was observed on top of Resident #49's bed partially covered with a blanket and clothing, on 9/19/23 at 1:00 PM and 9/20/21 at 11:05 AM. Resident #49 was admitted to the facility on 5/9/23 with diagnosis that included but were not limited to: diabetes, congestive heart failure, COPD (chronic obstructive pulmonary disease) and acute respiratory failure. A review of the comprehensive care plan dated 5/9/23 revealed, "FOCUS: The resident has altered respiratory status/difficulty breathing and COPD. INTERVENTIONS: OXYGEN SETTINGS: Bi-pap at night- FIO2 30 %." A review of the physician orders dated 6/13/23 revealed, "Bi-pap at night- FIO2 30% every evening and night shift for sob (shortness of breath). Bi-pap keep covered when not in use, every day shift." On 9/20/23 at 11:10 AM, an interview was conducted with LPN (licensed practical nurse) #2. When asked to observe Resident #49's bi-pap mask, LPN #2 stated, the resident must have taken the mask off at the end of night shift and is out for an appointment. LPN #2 stated they usually have a bag attached to the bedside cabinet that the mask can be put in with a date. The bag was not there for the resident to put the mask in. When asked if the mask should be laying on the bed, LPN #2 stated, no, the mask should not be laying on her bed due to infection control issues, it should be in a bag. On 9/21/23 at 1:20 PM, ASM (administrative staff	F 880	been stored properly when not in use. 2. An audit has been performed on all residents who use a bi-pap to ensure the bi-pap masks are stored appropriately when not in use. An audit has been performed on all residents who have a urinary catheter to ensure proper placement of the foley bag. Any discrepancies have been corrected. 3. The Director of Nursing/Designee will reeducate CNAs, LPNs, and RNs on the importance of following infection control practices. This education will include, but not be limited to, the importance of storing bi-pap masks properly and proper placement of foley bags. 4. The Director of Nursing/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure that bi-pap masks are stored properly and to ensure proper placement of foley bags. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 880	Continued From page 142	F 880		

member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings.

A review of the facility's "Resident Care Equipment-Cleaning" policy revealed, "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard."

No further information was provided prior to exit.

2. Resident #120's urinary catheter (Foley) bag was observed on the floor on 9/19/23 at 1:40 PM and 2:45 PM.

Resident #120 was admitted to the facility on 9/12/23 with diagnosis that included but were not limited to: diabetes,
osteomyelitis, sepsis and BPH (benign prostatic hypertrophy).

A review of the baseline care plan dated 9/14/23 revealed, "FOCUS: The resident has Indwelling Catheter:
history of BPH. INTERVENTIONS: The resident has 16 FR/10cc Position catheter bag and tubing below
the level of the bladder and away from entrance room door. Dignity bag to cover drainage bag content."

On 9/20/23 at 8:10 AM, an interview was conducted with RN (registered nurse) #2. When asked what was the proper placement of a Foley bag, RN #2 stated, it should be below the bladder

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F 880	Continued From page 143 level and is usually hung on the side of the bed. When asked if the Foley bag should be on the floor, RN #2 stated, no, it should never be on the floor. When asked why it should not be on the floor, RN #2 stated, it is against infection control practice. On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings. No further information was provided prior to exit.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to maintain a complete antibiotic stewardship program. The facility failed to evidence documentation of antibiotic use monitoring for December 2022. The findings include: The facility staff could not evidence antibiotic use monitoring for the month of December 2022.	F 881	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. It is the policy of Rosedale Health and Rehabilitation to maintain a complete antibiotic stewardship program. Rosedale Health and Rehabilitation has determined that all residents have the potential to be	11/3/23

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F 881	Continued From page 144 The antibiotic stewardship program was reviewed. The last twelve months were reviewed. There was no evidence of any monitoring for December 2022. A request was made on 9/19/2023 at 4:32 p.m., to ASM (administrative staff member) #1, the administrator, for the December documentation. On 9/20/2023 at 10:21 a.m. ASM #1 and ASM #2, the director of nursing, stated the facility did not have the documentation for December 2022. ASM #2 stated she attempted to get the records from the previous pharmacy and since she didn't have clearance any longer with that pharmacy, she was unable to access the report. ASM #1 and ASM #2 were made aware of the above concern. The facility policy, "Antibiotic Stewardship" documented in part, "Purpose: Antibiotics will be prescribed and administered to resident under the guidance of the facility's Antibiotic Stewardship Program. Implementation and Interpretation: 1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents." No further information was provided prior to exit.	F 881	affected by this alleged deficient practice. 2. Rosedale Health and Rehabilitation has evidence of the facility□s antibiotic stewardship program from January 2023 to current month. 3. The Director of Nursing/Infection Preventionist has educated all licensed clinical staff, including RNs and LPNs on the antibiotic stewardship program. The education included, but was not limited to, the importance of antibiotic stewardship in infection control, and the individual responsibilities of nurses in supporting and adhering to the antibiotic stewardship program. 4. The Director of Nursing /Designee will perform an audit of all antibiotics used in the facility weekly for 4 weeks and monthly for 2 months to ensure that antibiotics are administered, and antibiotic orders written, in accordance with the antibiotic stewardship program. Results of audits will be shared with the QAPI committee. Any patterns or trends will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. Date of Compliance: 11/3/23	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		11/3/23

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F 883	Continued From page 145 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 146 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide education and offer the pneumococcal vaccination for one of five residents reviewed for immunizations; Resident #108. The findings include: For Resident #108 (R108), the facility staff failed to provide education and offer the pneumococcal vaccination. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/8/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs it was coded the resident's pneumococcal vaccination was not up to date and that the resident had been offered and declined the vaccination. The electronic clinical record documented under	F 883	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #108 has been provided education and offered the pneumococcal vaccination. 2. An audit has been performed on all residents to ensure they have been provided education and offered the pneumococcal vaccination. Any discrepancies have been corrected. 3. The Director of Nursing/Designee will reeducate LPNs, and RNs on the importance of providing education and offering the pneumococcal vaccination offering. This education will include, but not be limited to, when to offer the pneumococcal vaccination and where to document the education and offering in the clinical chart.	

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F 883	Continued From page 147 Immunization tab; it was documented "Pneumovax 23 - consent refused." A request was made on 9/19/2023 at 4:30 p.m. for the documentation of the education provided and the documented declination for the pneumococcal vaccination. On 9/20/2023 the facility presented a form, "Pneumococcal Informed Consent" dated 9/19/2023 with the resident's signature. It was documented, "I hereby give the facility permission to administer a pneumococcal vaccination." An interview was conducted with R108 on 9/20/2023 at 8:49 a.m. When asked if he was offered a pneumonia vaccine before yesterday, 9/19/2023, R108 stated he couldn't recall being asked about it before yesterday. An interview was conducted with LPN (licensed practical nurse) #3 on 9/20/2023 at 9:56 a.m. When asked the process for screening for vaccination status of a new resident, LPN #3 stated, usually on admission she goes to the vaccination data base for Virginia. She stated she transfers the information into the clinical record. When explain R108's record documented consent refused, LPN #3 stated they ask the resident if they want the vaccines. Usually, we put it in the immunization tag. When asked if they provide any education to the resident related to the vaccines, LPN #3 explained prior to current ownership, they had a tab in the immunization tab to document the consent and education. They don't have it any longer. LPN #3 stated she had talked to R108 last evening and he agreed to take the pneumococcal vaccination.	F 883	4. The Director of Nursing/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months on all new admits ensuring that residents are provided education and offered the pneumococcal vaccination. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 883	Continued From page 148 The facility policy, "Pneumococcal Vaccine," documented in part, "Policy: Residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections...Specific Procedures/Guidance: 1. Prior to or upon admission, resident will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated." ASM (administrative staff member) #1, the administrator, was made aware of the above finding on 9/20/2023 at 10:30 a.m. No further information was provided prior to exit.	F 883		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to evidence bed inspections for one of 40 resident beds in the survey sample, Resident #52.	F 909	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #52□s bed rail inspection for	11/3/23

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F 909	Continued From page 149 The findings include: For Resident #52, the facility staff failed to perform bed rail inspections for the use of positioning/assist bars. A review of the comprehensive care plan dated 6/19/23, which revealed, "FOCUS: The resident is at risk for falls related to limited mobility. INTERVENTIONS: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Resident #52 was observed resting in bed on 9/19/23 at 1:20 PM, 9/20/23 at 8:50 AM and 9/21/23 at 8:00 AM with bilateral one quarter rails raised on bed. A review of the facility's "Side Rail Risk and Entrapment" form dated 6/19/23 revealed "Recommendations: Use both upper 1/4 rails for independent bed mobility. Reason for side rail use: to assist with bed positioning." An interview was conducted on 9/19/23 at 1:20 PM with Resident #52. When asked if he used the rails, Resident #52 stated, "Yes, I use the rails to turn in bed and to position myself." An interview was conducted on 9/19/23 at 2:54 PM with OSM (other staff member) #6, the maintenance director. When asked about bed inspections, OSM #6 stated, "We have no bed inspections. I have been here 4 weeks and am in the process of going through every bed to inspect and make sure they are safe for now and ordering parts that need to be replaced. Unable	F 909	the use of positioning/assist bars has been completed. 2. An audit has been performed on all residents□ bed rails. Any discrepancies have been corrected. 3. The Administrator will reeducate Maintenance Director on the importance of inspecting bed rails as part of a regular maintenance program to identify areas of possible entrapment. This education will include, but not be limited to, when beds, bed rails or mattresses are purchased or rented separately, the facility must ensure that the bed rails, mattress and bed frames are compatible. 4. The Administrator will conduct an audit weekly for 4 weeks and monthly for 2 months on the resident bed inspections to ensure bed rails have been inspected. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

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F 909	Continued From page 150 to locate any bed inspections for risk of entrapment prior to me starting. I called the previous director but he has not returned my calls." On 9/21/23 at 1:20 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant was made aware of the findings. A review of the facility's "Bed Rail Safety Inspection" policy, revealed, " To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall conduct regular bed safety inspections and will promote the following approaches: Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks. Review that gaps within the bed system are within the dimensions established by the FDA (Note: The review shall consider situations that could be caused by the resident's weight, movement or bed position.). Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.)." No further information was presented prior to exit.	F 909		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow	F 919		11/3/23

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F 919	Continued From page 151 residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. 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 ensure an accessible call bell in the bathroom for one of 40 residents in the survey sample, Resident #76. The findings include: For Resident #76 (R76), the facility staff failed to ensure the call light was within reach in the bathroom. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/15/2023, the residents cognition status was not assessed. Section G documented R76 requiring supervision for walking in the room and corridor and extensive assistance of one person for toileting. The resident was assessed as being frequently incontinent. On 9/19/2023 at 12:34 p.m., an observation was made of R76's bathroom. R76 was observed sitting on the side of their bed with a walker in front of them. The wall beside R76's commode contained a call light panel with no pull cord attached. The call light was observed to not be accessible to the resident from the floor if	F 919	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #76□s bathroom pull cord has been replaced and is now within reach. 2. An audit has been performed of all residents□ bathrooms to ensure that the call bell pull cords are in place. All deficiencies have been corrected. 3. The Administrator will reeducate the Maintenance Director on the importance of ensuring an accessible call bell is in place in the residents□ bathrooms. This education will include, but not be limited to, ensuring the pull cord is attached to the call bell. 4. The Maintenance Director/Designee will conduct an audit weekly for 4 weeks and monthly for 2 months to ensure residents□ bathrooms have an accessible call bell in place with the pull cord attached to the call bell. The Director of Nursing/Designee will identify any issues, patterns or trends and report to the	

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F 919	Continued From page 152 needed. At that time an interview was conducted with R76. R76 stated that the cord had come out of the wall over a week ago and they had taken the cord to the nurses station and given it to the nurse on duty at the time and asked them to have maintenance repair it. R76 stated that they used the bathroom and was scared that if they fell they would not be able to call anyone because they would not be able to reach the call light. R76 stated that the nursing staff had told them several times that they would have someone come fix the cord on the light but no one had come. Additional observations of R76's bathroom were made on 9/20/2023 at 8:55 a.m. and 9/20/2023 at 1:45 p.m. The call light in the bathroom remained without a pull cord accessible to the resident from the floor if needed. On 9/20/2023 at 2:13 p.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that they were not aware of any problems with any resident call lights on the unit. She stated that all residents should have access to the call light and if there were any problems with the call light they put in requisitions to have maintenance come to repair them. On 9/20/2023 at 2:23 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that all residents should have access to the call light when in the bathroom. She stated that it was a safety issue so they could call the staff if they needed assistance. On 9/20/2023 at 2:51 p.m., an interview was conducted with OSM (other staff member) #6, the director of maintenance. OSM #6 stated that they utilized a computer system which all staff were	F 919	Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEDALE HEALTH & REHABILITATION	1719 BELLEVUE AVENUE RICHMOND, VA 23227

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F 919	Continued From page 153	F 919		

able to enter work orders into for repairs. He stated that he checked the system at least once a day and added comments for repairs needed or closed out completed repairs. OSM #6 checked his maintenance requests for R76's bathroom call light and stated that it had not been reported to him. He observed the call light in R76's bathroom with no pull cord and stated that there should be a cord in place for the resident to be able to access it if needed.

The facility policy "Answering the Call light" documented in part, "The facility will maintain a functional call light system and will make all reasonable efforts to ensure timely responses to the resident's requests and needs...Explain to the resident that a call system is also located in his/her bathroom... Report all defective call lights to the licensed nurse and the maintenance promptly..."

On 9/21/2023 at 1:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.