STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495400	A. BUILDING _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CULPEPER	12425 VILLAGE LOOP CULPEPER, VA 22701

(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 10/16/23 through 10/18/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/16/23 through 10/18/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 47 certified bed facility was 39 at the time of the survey. The survey sample consisted of 19 current resident reviews and seven closed record reviews.	F 000		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to complete quarterly MDS (minimum data set) assessments in a timely manner for four of 26 residents in the survey sample, Residents #1, #48, #36 and #51.	F 638	1. Facility staff failed to complete quarterly MDS assessments in a timely manner for four out of 26 residents. The identified residents were found not to be affected by the deficient practice.	10/31/23

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

Electronically Signed | 11/02/2023

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F 638	Continued From page 1 The findings include: 1. For Resident #1 (R1), the facility staff failed to complete the resident's quarterly MDS with an ARD (assessment reference date) of 9/7/23 within 14 days. A review of R1's clinical record revealed a quarterly MDS assessment with an ARD of 9/7/23. Further review of R1's clinical record revealed the MDS was not completed until 9/30/23 (23 days). On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be completed within 14 days from the ARD. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern. The CMS RAI manual documented, "Completion Timing: - For all non-Admission OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD)." 2. For Resident #48 (R48), the facility staff failed to complete the resident's quarterly MDS with an ARD of 8/17/23 within 14 days.	F 638	2. Timely mds assessments must be completed for all residents, therefore, all residents have the potential to be affected by the deficient practice. 100% audit of current resident's quarterly mds schedule has been completed. Audit completed as of 10/30/23. Audit findings addressed and response in progress, with goal completion date of 11/22/23. 3. MDS Coordinator reeducated by D.O.N., on 10/18/23, as to the requirements related to timely completion of all mds assessments. An additional RN/RAC-CT has began assisting as MDS Resource, providing oversight to the process and to ensure timely completion of mds assessments. 4. Additional RN/RAC-CT MDS Resource will audit 100% of mds's for timely completion bimonthly x3 months. To begin week of 10/30/23. All findings will be reported immediately to DON and then to QAPI Committee for continued review and oversight. Any untimely mds findings will be immediately addressed. 5. 12/1/23 and ongoing	

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F 638	Continued From page 2	F 638		

A review of R48's clinical record revealed a quarterly MDS assessment with an ARD of 8/17/23. Further review of R48's clinical record revealed the MDS was not completed until 9/15/23 (29 days).

On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be completed within 14 days from the ARD. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments.

On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern.

3. For Resident #36 (R36), the facility staff failed to complete the resident's quarterly MDS with an ARD of 8/31/23 within 14 days.

A review of R36's clinical record revealed a quarterly MDS assessment with an ARD of 8/31/23. Further review of R36's clinical record revealed the MDS was not completed until 9/18/23 (18 days).

On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be completed within 14 days from the ARD. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments.

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F 638	Continued From page 3 On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern. 4. For Resident #51 (R51), the facility staff failed to complete the resident's quarterly MDS with an ARD of 8/24/23 within 14 days. A review of R51's clinical record revealed a quarterly MDS assessment with an ARD of 8/24/23. Further review of R51's clinical record revealed the MDS was not completed until 9/18/23 (25 days). On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be completed within 14 days from the ARD. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern.	F 638		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 640		10/31/23

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(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or,

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F 640	Continued From page 5 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to transmit MDS (minimum data set) assessments in a timely manner for six of 26 residents in the survey sample, Residents #1, #48, #36, #51, #56 and #55. The findings include: 1. For Resident #1 (R1), the facility staff failed to transmit a quarterly MDS with an ARD (assessment reference date) of 9/7/23 within 14 days of completion. A review of R1's clinical record revealed the resident's quarterly MDS assessment with an ARD of 9/7/23 was completed on 9/30/23. Further review of R1's clinical record revealed the MDS was not transmitted until 10/17/23 (17 days). On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when transmitting MDS assessments. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of	F 640	1. Facility staff failed to transmit MDS assessments in a timely manner for six of 26 residents. The identified residents were found not to be affected by the deficient practice. 2. All residents require mds assessments and they must be transmitted timely, therefore, all residents have the potential to be affected by the deficient practice. 100% audit of current resident's mds schedule has been completed. Audit completed as of 10/30/23. Audit findings addressed and response in progress, with goal completion date of 11/22/23. 3. MDS Coordinator reeducated by D.O.N., on 10/18/23, as to the requirements related to timely transmission of all mds assessments. An additional RN/RAC-CT has began assisting as MDS Resource, providing oversight to the process and to ensure timely transmission of mds assessments. 4. Additional RN/RAC-CT MDS Resource will audit 100% of completed mds's for timely transmission bimonthly x3 months. To begin week of 10/30/23. All findings will be reported to the D.O.N. and then to QAPI Committee for continued review and oversight. Any untimely mds transmission findings will be immediately addressed.	

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F 640	Continued From page 6 the above concern. The CMS RAI manual documented, "Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date." 2. For Resident #48 (R48), the facility staff failed to transmit a quarterly MDS with an ARD of 8/17/23 within 14 days after the completion date. A review of R48's clinical record revealed the resident's quarterly MDS assessment with an ARD of 8/17/23 was completed on 9/15/23. Further review of R48's clinical record revealed the MDS was not transmitted until 10/17/23 (32 days). On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when transmitting MDS assessments. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern. 3. For Resident #36 (R36), the facility staff failed to transmit a quarterly MDS with an ARD of 8/31/23 within 14 days after the completion date.	F 640	5. 12/1/23 and ongoing	

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A review of R36's clinical record revealed the resident's quarterly MDS with an ARD of 8/31/23 was completed on 9/18/23. Further review of R36's clinical record revealed the MDS was not transmitted until 10/17/23 (29 days).

On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when transmitting MDS assessments.

On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern.

4. For Resident #51 (R51), the facility staff failed to transmit a quarterly MDS with an ARD of 8/24/23 within 14 days after the completion date.

A review of R51's clinical record revealed the resident's quarterly MDS with an ARD of 8/24/23 was completed on 9/18/23. Further review of R51's clinical record revealed the MDS was not transmitted until 10/17/23 (29 days).

On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment

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Instrument) manual when transmitting MDS assessments.

On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern.

5. For Resident #56 (R56), the facility staff failed to transmit a discharge MDS assessment when the resident discharged to an assisted living apartment on 6/22/23.

R56 discharged to an assisted living apartment on 6/22/23. A review of the resident's clinical record failed to reveal a discharge MDS assessment was transmitted.

On 10/18/23 at 11:10 a.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated R56's discharge MDS should have been transmitted and was not.

On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern.

6. For Resident #55 (R55), the facility staff failed to transmit a discharge MDS assessment when the resident discharged to an assisted living apartment on 9/20/23.

R55 discharged to an assisted living apartment on 9/20/23. A review of the resident's clinical record failed to reveal a discharge MDS assessment was transmitted.

On 10/18/23 at 11:10 a.m., an interview was

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F 640	Continued From page 9 conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated R55's discharge MDS should have been transmitted and was not. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM #2, the director of nursing were made aware of the above concern.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable 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	F 656		10/31/23

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F 656	Continued From page 10 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for three of 26 residents in the survey sample, Residents #34, #12, and #51. The findings include: 1. For Resident #34 (R34), the facility staff failed to implement the care plan which instructed the staff to use a slow sip cup for fluid intake. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/19/23, R34 was coded as being as being severely cognitively impaired for making daily decisions. He was coded as coughing or choking during meals or when swallowing medications.	F 656	1. Facility staff failed to implement the comprehensive care plan for three of 26 residents, in the areas of required use of slow sip cup for fluid intake, application of palm protectors and provision of bowel medication regimen. Immediate actions were taken to address and correct the 3 identified issues upon discovery. The identified residents were found not to be affected by the deficient practice. 2. All residents have the potential to be affected by this deficient practice. 100% audit is being conducted to ensure resident's comprehensive care plans are being implemented in the areas of assistive devices, adaptive devices and bowel regimen. To be completed by 11/1/23.	

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F 656	Continued From page 11 On 10/16/23 at 3:40 p.m., R34 was observed sitting up in bed. He was drinking a liquid from a regular cup with a standard plastic straw. A two-handled slow sip cup was observed on R34's overbed table adjacent to his bed. RN (registered nurse) #2 was observed walking out of the resident's room as he was finishing sipping the liquid through the straw. A review of R34's clinical record revealed the following physician's order dated 7/6/23: "Regular Diet, Mechanical Soft, Ground. Thin Liquids. Slow Sip Cup." The review also revealed the following physician's order dated 6/6/23: "Pro-Stat...oral liquid...30 mls (milliliters) by mouth twice a day for skin health." A review of R34's comprehensive care plan dated 9/14/23 revealed, in part: "Provide slow sip cup for fluids." On 10/17/23 at 3:35 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated the purpose of the care plan is to tell the staff how best to meet a resident's needs. She stated the nurses and CNAs (certified nursing assistants) are responsible for implement the care plan. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1, the executive director, #2, the director of nursing, ASM #3, the assisted living administrator, and LPN #1, the quality improvement nurse, were informed of these concerns. A review of the facility policy, "Comprehensive Person-Centered Care Planning," revealed, in part: "The resident will receive the services and/or	F 656	3. All Licensed Staff will be re-educated by DON or designee, on the requirements of implementing an effective comprehensive care plan in the areas of use of slow sip cups for fluid intake, application of palm protectors, and provision of bowel medication regimen. Re-education to be completed by 11/22/23. 4. DON or designee will complete audit of 50% of residents with care plan interventions in the areas of adaptive/assistive devices (including feeding) and bowel medication regimens, to ensure that care plan interventions are being implemented appropriately. Audits to be completed weekly x 4 weeks and then monthly x2 months. Issues identified during audits will be addressed immediately. Results of the audits will be reviewed and discussed at the QAPI Committee for continued review and oversight. Audits to begin week of 11/27/23. 5. 12/1/23 and ongoing	

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F 656	Continued From page 12	F 656		

items included in the plan of care."

No further information was provided prior to exit.

2. For Resident #12 (R12), the facility staff failed to implement the care plan to apply both right and left palm protectors to prevent pain.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/23, R12 was coded as requiring the extensive assistance of two staff members for dressing and personal hygiene, and as having impairment in range of motion on both sides of her upper extremities.

On 10/16/23 at 11:22 a.m. and 3:36 p.m., R12 was observed in her wheelchair and did not have palm protectors on either hand. On 10/17/23 at 8:34 a.m., R12 was observed in her wheelchair and had a palm protector on her right hand, but not on her left.

A review of R12's clinical record revealed the following physician order dated 1/11/23: "Bilateral palm protector splints. Apply in morning. Remove at bedtime. Resident to wear throughout the day as resident will allow...For pain r/t (related to)...contracture." The resident's progress notes for 10/16/23 and 10/17/23 contained no information related to the resident's palm protectors.

A review of R12's care plan dated 2/11/23 revealed, in part: "[R12] wears...bilateral palm protectors during the day...Bilateral palm protectors - apply in the morning and remove at bedtime...for pain."

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F 656	Continued From page 13	F 656		

On 10/17/23 at 3:35 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated she is familiar with caring for R12. She stated if there is an order for the palm protectors on both hands, the resident should have them on both hands. She stated the purpose of the care plan is to tell the staff how best to meet a resident's needs. She stated the nurses and CNAs (certified nursing assistants) are responsible for implementing the care plan.

On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1, the executive director, #2, the director of nursing, ASM #3, the assisted living administrator, and LPN #1, the quality improvement nurse, were informed of these concerns.

No further information was provided prior to exit.
3. For Resident #51 (R51), the facility staff failed to implement the resident's comprehensive care plan for bowel medication.

A review of R51's clinical record revealed a physician's order dated 4/4/23 for a bisacodyl suppository, ten milligrams- administer one suppository rectally one time a day as needed for no bowel movement in three days.

R51's comprehensive care plan dated 6/22/23 documented, "Potential for Alteration in Bowel Elimination as related to: impaired mobility. Constipation...Administer medication as ordered by the physician..."

A review of R51's bowel movement records revealed the resident did not have a bowel movement from 7/3/23 until 7/9/23. Further

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F 656	Continued From page 14 review of R51's clinical record and review of a 24-hour report sheet dated 7/7/23 revealed a suppository was not administered to R51 until 7/7/23 (five days after the resident had not had a bowel movement). On 10/18/23 at 11:18 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan is that it, "Kind of describes what you are supposed to do to take care of them [the residents]. It's the plan of care." LPN #3 stated nurses can access residents' care plans in the computer system. LPN #3 reviewed R51's bisacodyl order and stated a suppository should have been given to the resident within three days of the resident not having a bowel movement. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.	F 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.	F 657		10/31/23

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F 657	Continued From page 15 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of 26 residents in the survey sample, Resident #47. The findings include: For Resident #47 (R47), the facility staff failed to review and revise the resident's comprehensive care plan for the use of floor mats. A review of R47's clinical record revealed a physician's order dated 3/16/22 for floor mats next to the bed while the resident is in the bed. R47's comprehensive care plan dated 2/3/22 failed to reveal documentation regarding floor mats. On 10/16/23 at 11:34 a.m. and 10/17/23 at 8:54 a.m., R47 was observed lying in bed. A mat was observed on the right side of the bed, but a mat was not on the left side of the bed.	F 657	1. Facility staff failed to review and revise the comprehensive care plan for one of 26 residents for the use of floor mats. Immediate action was taken to address and correct the identified issue upon discovery on 10/16/23. The identified care plan was revised on 10/26/23 by MDS Coordinator. 2. All residents with order for floor mats, have the potential to be affected by this deficient practice. 100% of comprehensive care plans were reviewed by Unit Manager on 10/26/23, to ensure that all appropriate resident careplans reflect use of floor mats. 3. MDS Coordinator re-educated by D.O.N., on 10/26/23, regarding requirements of reviewing and revising careplans regarding floor mat usage. 4. DON or designee will complete audit of	

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F 657	Continued From page 16 On 10/17/23 at 3:34 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the purpose of the care plan is that "It tells about how to meet their [residents'] needs the best." LPN #2 stated residents' care plans should be reviewed and revised to include the use of floor mats, so everyone knows to implement the mats. On 10/17/23 at 4:38 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, "Comprehensive Person-Centered Care Planning" documented, "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans..."	F 657	50% of resident careplans weekly x4 weeks, then monthly x2 months, for those residents that have floor mats ordered. Care plans found to have missing information will be corrected immediately. Results of the audits will be reviewed and discussed at QAPI meeting for continued review and oversight. Audits to begin week of 11/27/23. 5. 12/1/23 and ongoing	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive 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 staff interview, facility document review and clinical record review, the facility staff failed to provide care and services to promote a resident's highest level of well-being for one of 26	F 684	1. Facility staff failed to provide care and services to promote a resident's highest level of well-being for one of 26 residents; by failing to administer a bisacodyl	11/1/23

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F 684	Continued From page 17 residents in the survey sample, Resident #51. The findings include: For Resident #51 (R51), the facility staff failed to administer a bisacodyl suppository per the physician's order. A review of R51's clinical record revealed a physician's order dated 4/4/23 for a bisacodyl suppository, ten milligrams- administer one suppository rectally one time a day as needed for no bowel movement in three days. A review of R51's bowel movement records revealed the resident did not have a bowel movement from 7/3/23 until 7/9/23. Further review of R51's clinical record and review of a 24-hour report sheet dated 7/7/23 revealed a suppository was not administered to R51 until 7/7/23 (five days after the resident had not had a bowel movement). R51 did not have a bowel movement until 7/9/23. On 10/18/23 at 11:18 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the computer generates a list of residents who have not had a bowel movement in two days. LPN #3 stated if a resident has not had a bowel movement in two days, then the nurses activate standing orders or reach out to the physician. LPN #3 reviewed R51's bisacodyl order and stated a suppository should have been given to the resident three days after not having a bowel movement. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made	F 684	suppository per the physician's order. The identified resident was found not to be affected by this deficient practice. 2. All residents have the potential to be affected. All residents with orders for bisacodyl suppository, were reviewed to ensure orders are being followed appropriately. Review was completed on 10/26/23 by Nurse Manager. No further deficient practice was identified. 3. Re-education will be provided to all Licensed Nurses regarding proper bowel regimen protocol and requirements of following physician orders. Re-education will be completed by 11/22/23, by D.O.N. or designee. 4. Audit will be conducted by D.O.N. or designee, on 50% of residents on prn bowel regimen to ensure physician orders are being followed. Audits to begin week of 11/27/23, will be completed weekly x4 weeks, and then monthly x2 months. Any identified deficient practice will be addressed immediately. All audit results will be reviewed and discussed at QAPI Meeting for continued review and oversight. 5. 12/1/23 and ongoing	

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F 684	Continued From page 18 aware of the above concern. The facility policy titled, "Constipation/Fecal Impaction" documented, "IV. Nurse in charge will be notified of signs and symptoms of constipation. Constipation will be treated with oral laxative, suppository or enema as ordered by the physician..."	F 684		
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, staff interview, facility document review and clinical record review, the facility staff failed to implement a fall intervention for one of 26 residents in the survey sample, Resident #47. The findings include: For Resident #47 (R47), the facility staff failed to implement physician ordered floor mats. A review of R47's clinical record revealed a physician's order dated 3/16/22 for floor mats next to the bed while the resident is in the bed. Further review of R47's clinical record revealed the resident sustained a fall on 1/6/23, 3/4/23, 4/2/23, and 8/16/23.	F 689	1. Facility staff failed to implement a fall intervention for one of 26 residents. Resident was found to have 1 floor mat instead of two floor mats beside her bed. The additional floor mat was placed by resident's bed immediately upon discovery on 10/17/23. The identified resident was found not to be affected by the deficient practice. 2. All residents with an order for floor mats have the potential to be affected by the deficient practice. All residents with orders for floor mat usage, were audited on 10/26/23 by Nurse Manager, and no other deficient practice was identified.	11/1/23

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F 689	Continued From page 19 On 10/16/23 at 11:34 a.m. and 10/17/23 at 8:54 a.m., R47 was observed lying in bed. A mat was observed on the right side of the bed, but a mat was not on the left side of the bed. On 10/17/23 at 3:34 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the nurses are aware of the need for floor mats via physician's orders and then the nurses tell the certified nursing assistants who needs floor mats. LPN #2 reviewed R47's physician's order for floor mats and stated that if plural floor mats are ordered then that would mean a floor mat should be placed on each side of the bed. On 10/17/23 at 4:38 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Fall Management Program" documented, "Other potential fall preventative interventions for residents at high risk: b) Floor mats..."	F 689	3. Re-education will be provided to all Licensed Nurses regarding required implementation of all fall interventions specific to physician order and per resident's comprehensive care plan. Re-education will be provided by D.O.N. or designee, by 11/22/23. 4. D.O.N. or designee will audit 100% of residents for proper safety device placement of fall mats, weekly x4 weeks and then monthly x2 months. Any issues identified during the audits will be addressed immediately. Results of the audits will be reported to the QAPI Committee for continued review and oversight. Audits will begin week of 11/27/23. 5. 12/1/23 and ongoing	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 697	1. Facility staff failed to apply an adaptive	11/1/23

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F 697	Continued From page 20 document review, and clinical record review, the facility staff failed to apply an adaptive device to prevent pain for one of 26 residents in the survey sample, Resident #12. The findings include: For Resident #12 (R12), the facility staff failed to apply both right and left palm protectors to prevent pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/23, R12 was coded as requiring the extensive assistance of two staff members for dressing and personal hygiene, and as having impairment in range of motion on both sides of her upper extremities. On 10/16/23 at 11:22 a.m. and 3:36 p.m., R12 was observed in her wheelchair, and did not have palm protectors on either hand. On 10/17/23 at 8:34 a.m., R12 was observed in her wheelchair, and had a palm protector on her right hand, but not on her left. A review of R12's clinical record revealed the following physician order dated 1/11/23: "Bilateral palm protector splints. Apply in morning. Remove at bedtime. Resident to wear throughout the day as resident will allow...For pain r/t (related to)...contracture." The resident's progress notes for 10/16/23 and 10/17/23 contained no information related to the resident's palm protectors. A review of R12's care plan dated 2/11/23 revealed, in part: "[R12] wears...bilateral palm protectors during the day...Bilateral palm	F 697	device to prevent pain for one of 26 residents. The adaptive device was immediately placed on resident as ordered, upon discovery. The identified resident was found not to be affected by the deficient practice. 2. All residents with adaptive devices to prevent pain have the potential to be affected. 100% of residents with orders for adaptive devices were audited on 10/27/23 by Nurse Manager, to ensure proper application of adaptive devices per physician order, no other deficient practice found. 3. All licensed Nurses will be re-educated by D.O.N. or designee, regarding requirements of following physician orders for pain management, to include properly applying palm protectors per orders. Re-education will be completed by 11/22/23. 4. D.O.N. or designee will audit 100% of residents with orders for adaptive devices for pain management, to ensure the adaptive devices are being applied per physician order to prevent pain. Any issues identified during the audits, will be addressed immediately. Audits will be completed weekly x4 weeks and then monthly x2 months. Results of the audits will be reported to the QAPI Committee for continued review and oversight. Audits to begin week of 11/27/23. 5. 12/1/23 and ongoing	

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F 697	Continued From page 21 protectors - apply in the morning and remove at bedtime...for pain." On 10/17/23 at 3:35 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated she is familiar with caring for R12. She stated if there is an order for the palm protectors on both hands, the resident should have them on both hands. If a resident refuses or will not tolerate them, the nurse should write a progress note indicating this. She stated R12 has contractures in both hands, and the palm protectors can aid in relieving the pain of the contractures. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1, the executive director, #2, the director of nursing, ASM #3, the assisted living administrator, and LPN #1, the quality improvement nurse, were informed of these concerns. In response to a request for the facility policy regarding palm protectors, the facility staff provided the policy, "Skin Integrity." A review of this policy revealed no information related to applying palm protectors as ordered by the physician. No further information was provided prior to exit.	F 697		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.	F 810		11/1/23

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F 810	Continued From page 22 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 use an adaptive feeding device for one of 26 residents in the survey sample, Resident #34. The findings include: For Resident #34 (R34), the facility failed to utilize a slow sip cup for fluids on 10/16/23. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/19/23, R34 was coded as being as being severely cognitively impaired for making daily decisions. He was coded as coughing or choking during meals or when swallowing medications. On 10/16/23 at 3:40 p.m., R34 was observed sitting up in bed, and was drinking a liquid from a regular cup with a standard plastic straw. A two-handled slow sip cup was observed on R34's overbed table adjacent to his bed. RN (registered nurse) #2 was observed walking out of the resident's room as he was finishing sipping the liquid through the straw. A review of R34's clinical record revealed the following physician's order dated 7/6/23: "Regular Diet, Mechanical Soft, Ground. Thin Liquids. Slow Sip Cup." The review also revealed the following physician's order dated 6/6/23: "Pro-Stat...oral liquid...30 mls (milliliters) by mouth twice a day for skin health." A review of R34's comprehensive care plan dated	F 810	1. Facility staff failed to use an adaptive feeding device (slow sip cup for fluids) for one of 26 residents. This was addressed immediately with on duty nurse, upon notification of findings, on 10/16/23. The identified resident was found not to be affected by the deficient practice. 2. All residents with orders for adaptive feeding devices have the potential to be affected by the deficient practice. 100% of residents with adaptive feeding devices have been evaluated for proper use per physician order, audit was completed 10/30/23. . 3. All Licensed staff will be re-educated by D.O.N. or designee, on the requirements of consistently following physician orders for all adaptive feeding devices. This re-education will be completed by 11/22/23. 4. D.O.N. or designee will audit 100% of residents with orders for adaptive feeding devices to ensure these devices are being utilized per physician orders. Audit will be 100% weekly x4 weeks, and then monthly x2 months. Audits to begin week of 11/27/23. Any deficient findings will be addressed immediately. All audit results will be reported to the QAPI Committee for continued review and oversight. 5. 12/1/23 and ongoing	

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	495400	A. BUILDING _____ B. WING _____	10/18/2023

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F 810	Continued From page 23 9/14/23 revealed, in part: "Provide slow sip cup for fluids." On 10/16/23 at 3:50 p.m., RN #2 was interviewed. She stated she "thought" R34 was supposed to be using the slow sip cup for fluids since she saw it on the overbed table. She stated: "I guess I just didn't realize what he needed at the time." On 10/18/23 at 11:18 a.m., LPN (licensed practical nurse) was interviewed. She stated for R34, his dietary orders, including the slow sip cup, appear at the top of his information when anything about him is accessed on the electronic medical record. She stated his order for a slow sip cup appears as a warning at the top of the screen. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1, the executive director, #2, the director of nursing, ASM #3, the assisted living administrator, and LPN #1, the quality improvement nurse, were informed of these concerns. A review of the policy, "Adaptive Feeding Program," revealed in part: "Nursing staff...will be responsible for observing individualized resident feeding needs and response to any modifications in resident's plan of care." No further information was provided prior to exit.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		11/1/23

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F 812	Continued From page 24 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility failed to prepare and store food in a sanitary manner in one of two nourishment refrigerators, the rehab to home unit refrigerator, and in one of two facility kitchens, the main kitchen. The findings include: The facility staff failed to maintain a clean main kitchen, and failed to store food safely in the main kitchen and in the rehab to home unit refrigerator. On 10/16/23 at 10:15 a.m., observation was made of the main facility kitchen. The upper oven contained a large amount of baked-on grease and dark particles on the doors, sides, bottom and back. The areas around the burners on the stove contained cooked-on grease, and a large amount of crumbs and dark black debris. OSM	F 812	1 a. Facility staff failed to prepare and store food in a sanitary manner in one of two nourishment refrigerators, the rehab to home unit refrigerator, and in one of two facility kitchens, the main kitchen. 1. b. Facility staff failed to maintain a clean main kitchen. All identified issues were immediately addressed upon discovery; the main kitchen oven and stove top were immediately deep cleaned on 10/16/23 and all items discovered not labeled/dated on 10/16/23 and 10/17/23 were immediately discarded. No residents were determined to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practices of keeping an unclean kitchen and	

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F 812	Continued From page 25 (other staff member) #1, the director of dining services, stated: "It all could use a good cleaning." She stated the oven and stove get a deep cleaning weekly, but should also be spot cleaned after each use. In the walk in freezer, a 10" by 10" plastic container of red frozen material rested on a shelf. There was no label on the container to indicate the use-by date or what the red material was. OSM #1 stated the material in the plastic container should have been labeled, and needed to be discarded. She stated all items in the walk-in freezer should be labeled. On 10/17/23 at 3:22 p.m., observation was made of the nourishment refrigerator on the rehab to home unit. The refrigerator contained a small plastic container of potstickers and a small container of sauce. Neither container was labeled. The freezer contained a bag of chocolate covered coffee beans; the bag was not labeled. On 10/18/23 at 9:37 a.m., OSM #1 stated the unit nourishment refrigerators were the responsibility of the dining services staff. She stated the dining services staff are supposed to check the unit refrigerators and freezers each time they deliver food to the units. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1, the executive director, #2, the director of nursing, ASM #3, the assisted living administrator, and LPN (licensed practical nurse) #1, the quality improvement nurse, were informed of these concerns. A review of the facility policy, "Cleaning and Sanitation of Dining and Food Service Areas," revealed, in part: "The food and nutrition services staff will maintain the cleanliness and sanitation	F 812	unlabeled/undated food items. All equipment in Main Kitchen was evaluated and deep cleaned as needed on 10/18/23. All freezers and refrigerators were inspected, any additional undated/unlabeled food items were discarded immediately on 10/16/23, 10/17/23, and 10/18/23. 3. All dining staff will be re-educated on required cleaning procedures in the kitchen and required labeling/dating of all food items in all refrigerators. Re-education will be completed by the Director of Dining Services or designee by 11/22/23. All nursing staff will be re-educated on proper labeling/dating of all food items and food items that are appropriate to be kept in the refrigerators on the units. Re-education will be completed by the D.O.N. or designee by 11/22/23. Signage will be placed on all refrigeration units, with the guidance for labeling & dating of food, by 11/10/23. Daily "cleaning duties" checklist/sign off will be posted , along with staff checklist for checking all food items for label/dates in the refrigerators. These checklists/sign offs will begin after re-education is provided, implementation 11/23/23. Executive Chef or designee will conduct a one time evaluation/audit of current equipment cleaning products, to ensure products are effectively cleaning equipment upon use (such as oven and	

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F 812	Continued From page 26 of the dining and food service areas through compliance with a written, comprehensive cleaning schedule...Staff will be trained in the frequency of cleaning, as necessary...Staff will be held accountable for cleaning assignments." A review of the facility policy, "Food Storage," revealed, in part: "Frozen Foods...All foods should be covered, labeled, and dated. All foods will be checked to assure foods will be consumed by their use by dates or discarded." No further information was provided prior to exit.	F 812	stove top) and will provide findings to Director of Dining. This evaluation will be completed by 11/10/23. 4. The Executive Chef or designee will audit the new "cleaning duties" checklists/sign off sheets and checklist/sign off sheets for labeling/dating of all food items. Audit will be done daily x4 weeks, and then 3x/week for 4 weeks, and then twice weekly for 4 weeks. Audits to begin week of 11/27/23. Any deficient findings will be addressed immediately. The Executive Chef or designee will also visually inspect the Kitchen equipment (oven, stove top..) for cleanliness and inspect freezer and unit refrigerators for proper labeling and dating of food items. This will be done twice weekly x2 months and then weekly x1 month. Audits to begin week of 11/27/23. Any deficient findings will be addressed immediately. All Audit findings will be reported to the QAPI Committee for further review and oversight. 5. 12/1/23 and ongoing	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		11/1/23

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F 842	Continued From page 27	F 842		

except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight 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-

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F 842	Continued From page 28 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of 26 residents in the survey sample, Resident #51. The findings include: For Resident #51, the facility staff failed to document the administration of a bisacodyl suppository on 7/7/23. A review of R51's clinical record revealed a physician's order dated 4/4/23 for a bisacodyl suppository, ten milligrams- administer one suppository rectally one time a day as needed for no bowel movement in three days. R51's July 2023 MAR (medication administration record) documented the same order.	F 842	1. Facility staff failed to maintain a complete and accurate clinical record for one of 26 residents, by failing to document the administration of an as needed bisacodyl suppository. The identified resident was found to not be affected by the deficient practice. 2. All residents with a prn bisacodyl suppository order have the potential to be affected by the deficient practice. All residents with physician's order for (prn) as needed bisacodyl suppository were reviewed on 10/26/23, by Nurse Manager, and found to have been documented and compliant with physician order. 3. All Licensed Nurses will be re-educated on the requirement of documenting and	

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F 842	Continued From page 29 A review of a 24-hour report sheet dated 7/7/23 revealed documentation that R51 was administered a suppository on that date. Further review of R51's clinical record, including the July 2023 MAR and nurses' notes for 7/7/23, failed to reveal documentation that R51 was administered a suppository. On 10/18/23 at 11:18 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that if a nurse administers a suppository, the nurse should write a note and sign the medication off on the MAR. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Medication Administration and Documentation" documented, "On administering a prn (as needed) med, the nurse charts the administration in e-MAR (electronic medication administration record) and effectiveness..."	F 842	accurately recording in resident electronic medication administration record, all medications administered per physician order (including prn bisacodyl suppositories). Re-education will be provided by 11/22/23, by D.O.N. or designee. 4. D.O.N. or designee will audit 50% of residents with prn bowel regimen to ensure prn bowel regimen medications are documented in the electronic medical record. Will compare 24 hour report sheet to resident's electronic medication administration record to ensure a complete and accurate clinical record. Audit will be completed weekly x4 weeks and then monthly x2 months. Any deficient findings will be addressed immediately. All audit findings will be reported to the QAPI Committee for continued review and oversight. 5. 12/1/23 and ongoing	