STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 11/15/2023

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AMELIA REHABILITATION AND HEALTHCARE CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(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 11/13/2023 through 11/15/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/13/2023 through 11/15/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey (VA00059734 was unsubstantiated with an unrelated deficiency and VA00060010 was substantiated with deficiency). The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 99 at the time of the survey. The survey sample consisted of 36 current resident reviews and 6 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		12/30/23

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

Electronically Signed | 12/06/2023

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide a dignified dining experience for one of 42 residents in the survey sample, Resident #16. The findings include: For Resident #16 (R16), the facility staff failed to	F 550	The resident has been provided with proper utensils and dishware, so they have a dignified dining experience. An audit was completed by the Dietary Manager on 12/4/2023 to ensure residents were served meals on standard dishware, no other residents were noted to be affected.	

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F 550	Continued From page 2 provide lunch in a dignified manner on 11/13/23. R16 was served a meal on a Styrofoam plate and given plastic utensils. A review of R16's clinical record failed to reveal documentation that R16 should be served meals on a Styrofoam plate or given plastic utensils (the resident was not on isolation and did not present with dangerous behaviors). On 11/13/23 at 1:20 p.m., R16 was observed sitting up in bed and eating lunch. The resident's meal was on a Styrofoam plate and the resident was eating with plastic utensils. On 11/14/23 at 2:50 p.m., an interview was conducted with OSM (other staff member) #5 (the dietary director). OSM #5 stated that when she began employment 45 days ago, a lot of plates did not match, and she did not have enough plates. OSM #5 stated she requested four cases (each case containing 36 plates) of plates and had only received two cases. OSM #5 stated there was also a shortage of utensils and she had ordered multiple boxes of utensils because they get thrown in the trash or stockpiled in resident rooms. OSM #5 stated dining with a Styrofoam plate and plastic utensils is not dignified. On 11/14/23 at 4:57 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. ASM #1 stated four cases of plates had been ordered but two cases had not yet been received. The facility policy titled, "Dignity" documented, "5. When assisting with care, residents are supported in exercising their rights. For example,	F 550	Dietary Management will be educated by the Administrator on a dignified dining experience to ensure that residents are provided dignified dishware. The education will be completed by 12/8/2023. The Dietary Manager or designee will complete a dining observation to ensure that residents are provided dignified dishware weekly for 4 weeks, monthly for 2 months. The Dietary Manager will bring the results of the audits to the monthly QAPI meeting x 3 months or until compliance is achieved	

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F 550	Continued From page 3 residents are: e. provided with a dignified dining experience..."	F 550		
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 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.	F 580		12/30/23

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F 580	Continued From page 4 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify the physician of a potential need to alter treatment for one of 42 residents in the survey sample, Resident #20. The findings include: For Resident #20 (R20), the facility staff failed to notify the physician when the resident's medication Gemtesa (1) was not available for administration on multiple dates in September 2023. A review of R20's clinical record revealed a physician's order dated 7/10/23 for Gemtesa 75 mg (milligrams)- one tablet by mouth in the morning for overactive bladder. A review of R20's September 2023 MAR (medication administration record) revealed the same physician's order for Gemtesa. On 9/4/23, 9/5/23, 9/6/23, 9/7/23 and 9/9/23, the MAR documented the code, "9= Other/ See Progress Notes." A nurse's note	F 580	Resident #20 was assessed for any negative outcomes from the missed medications, and none were noted. The MD and RP were notified of the missed medications on 12/5/2023. The Director of Nursing or designee will review the missed medication MAR report for the last 3 days to ensure that if medications were missed that the MD/RP were both notified. The audit was completed on 12/5/2023 The DON or designee will educate all licensed nurses on medication administration and medication availability including notifying the MD of medications not given. The education will be completed by 12/8/2023 The DON or designee will audit the missed medication MAR report weekly for 4 weeks, then monthly x2 to ensure that if	

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F 580	Continued From page 5	F 580		

dated 9/4/23 documented, "Medication pending pharmacy." A nurse's note dated 9/5/23 documented, "Waiting on delivery from pharmacy." A nurse's note dated 9/6/23 documented, "Awaiting pharmacy delivery." A nurse's note dated 9/7/23 documented, "Waiting to be delivered by pharmacy." A nurse's note dated 9/9/23 documented, "Waiting for pharmacy to deliver." Further review of R20's clinical record failed to reveal the resident's physician was notified and made aware the medication was not available for administration.

On 11/14/23 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated nurses should notify the physician when a resident's medication is not available for administration because the doctor gave the order to give the medication for a reason, so the doctor needs to know if the medication is missed.

On 11/14/23 at 4:57 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, "Notification of Change" documented, "1. The nurse will notify the resident's Attending Physician / practitioner or physician on call when there has been a(an): e. Need to alter the resident's medical treatment significantly..."

Reference:
(1) Gemtesa is used to treat overactive bladder. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a621015.html

medications were not administered that the MD/RP were notified. Results of audits will be taken to QAPI committee monthly x3 for review and revised as needed.

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F 622	Continued From page 6	F 622		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §	F 622		12/30/23

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F 622	Continued From page 7	F 622		

431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information

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F 622	Continued From page 8 (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. 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 evidence the required clinical documents were sent to the hospital for a facility-initiated transfer for three of 42 residents in the survey sample, Residents #82, #32, and #5. The findings include: 1. For Resident #82 (R82), the facility staff failed to evidence what documents were sent to the hospital with the resident on 8/10/2023. The nurse's notes 8/10/2024 at 8:10 p.m. documented in part, "I was called to resident room by assigned CNA (certified nursing assistant) of this resident. When I arrived in the resident room, he was noted laying on this left side, on the L (left) side of his bed, noted his left arm under him. Resident was noted with his left side of his face to the floor. Resident was wearing his eyeglasses at the time of the fall; Resident eyeglasses was noted broken on the floor beside him. When assessed, Resident was noted with swelling to his L. eye/L side of face, (2) Lacerations to L. Side temple/hair line area, L. eye red and swollen, C/O (complained of) L.	F 622	Unable to retroactively correct for residents #82, #32, and #5. The Medical Records or designee will audit Acute transfers for the last 7 days to ensure that the discharge transfer documents have been sent as required. This audit was completed on 12/01/2023. The Director of Nursing or designee will educate all licensed nurses on completing a discharge or transfer with the required clinical documentation with signature as proof. The education will be completed by 12/8/2023. The Medical Records or designee will audit the discharge or transfer assessments to ensure evidence of required documents being sent with the resident weekly x four and then monthly x2. The findings of the audits will be provided to the monthly QAPI meeting x 3 months.	

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F 622	Continued From page 9	F 622		

shoulder/arm pain, Laceration to L. side of mouth...On call contacted and gave verbal order to send (R82) to hospital E.R (emergency room) for further evaluation and treatment. (Name of town) EMS (emergency medical services) contacted and transported (R82) to (Name of Hospital), R.P. (responsible party) made aware (name of RP) (Name of nurse practitioner) made aware and gave verbal order."

A copy of evidence of what documents were sent to the hospital for the transfer of 8/10/2023 was requested on 11/14/2023 at 11:37 a.m. however no documents were received.

An interview was conducted with LPN (licensed practical nurse) #5 on 11/14/2023 at 4:16 p.m. When asked what documents are sent to the hospital when a resident is sent out, LPN #5 stated they send the face sheet, any pertinent laboratory test results, doctor's notes, nurse's notes, if the resident is a DNR (do not resuscitation), send that form, care plan, bed hold notice and medication list. LPN #5 was asked where it is documented that those documents are sent to the hospital, LPN #5 stated there should be documentation in the nurse's notes.

A copy of the policy regarding documentation related to a hospital transfer was requested on 11/15/2023 at 8:40 a.m. The policy presented, "Transfer and Discharge Notice," did not address the required documents to be sent with a resident at the time of a facility-initiated transfer.

ASM (administrative staff member) #1, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 5:04 p.m.

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F 622	Continued From page 10	F 622		

No further information was provided prior to exit.

2. For Resident #32, the facility staff failed to evidence what documents were sent to the hospital with the resident on 10/30/2023.

The nurse practitioner (NP) note dated, 10/30/2023 documents in part, "Patient's labs showed significant anemia, no signs of bleeding but given patient history and her feeling unwell send to ER (emergency room) to rule out bleed. Patient has a risk of decompensation."

The nurse's note dated, 10/30/2023 at 10:00 a.m. documented, "NP aware of sending out." The nurse's note dated, 10/30/2023 at 11:19 a.m., "Squad picked up to send to ED (emergency department) for evaluation."

There was no documentation of what was sent to the ED with the resident.

A copy of evidence of what documents were sent to the hospital for the transfer of 10/30/2023 was requested on 11/14/2023 at 11:37 a.m.

The SNF/NF to Hospital Transfer Form dated 10/30/2023 failed to evidence what documents were sent with the resident. The Acute Care Transfer Document Checklist dated 10/30/2023 was blank. The form didn't have a check off for the comprehensive care plan goals to be sent with the resident.

An interview was conducted with LPN (licensed practical nurse) #5 on 11/14/2023 at 4:16 p.m. When asked what documents are sent to the hospital when a resident is sent out, LPN #5

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stated they send the face sheet, any pertinent laboratory test results, doctor's notes, nurse's notes, if the resident is a DNR (do not resuscitation), send that form, care plan, bed hold notice and medication list. LPN #5 was asked where it is documented that those documents are sent to the hospital, LPN #5 stated there should be documentation in the nurse's notes.

ASM (administrative staff member) #1, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 5:04 p.m.

No further information was provided prior to exit.

3. For Resident #5, the facility staff failed to evidence what documents were sent to the hospital with the resident on 11/12/2023.

The nurse's note dated, 11/12/2023 at 9:58 p.m. documented, "Notified MD (medical doctor) about a ground level fall that happened when she tried to go to the bathroom. Notified the on-call doctor that she is complaining of pain at 8 out of 10 in her neck. No other injury noted. MD said since she had neck pain to send her out to the hospital to be evaluated. Primary nurse notified RP about the fall and sending her out to the hospital. 911 called an ambulance crew is on the way to take her to the nearest hospital to be evaluated."

The nurses' note dated, 11/12/2023 at 10:22 p.m. documented, Ambulance crew here to pick up patient and transport her to the nearest hospital. Information packet given to squad members."

A copy of evidence of what documents were sent to the hospital for the transfer of 11/12/2023 was

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	495358	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA REHABILITATION AND HEALTHCARE CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(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 622	Continued From page 12 requested on 11/14/2023 at 11:37 a.m. however no further documents were provided. An interview was conducted with LPN (licensed practical nurse) #5 on 11/14/2023 at 4:16 p.m. When asked what documents are sent to the hospital when a resident is sent out, LPN #5 stated they send the face sheet, any pertinent laboratory test results, doctor's notes, nurse's notes, if the resident is a DNR (do not resuscitation), send that form, care plan, bed hold notice and medication list. LPN #5 was asked where it is documented that those documents are sent to the hospital, LPN #5 stated there should be documentation in the nurse's notes. ASM (administrative staff member) #1, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 5:04 p.m. No further information was provided prior to exit.	F 622		
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;	F 623		12/30/23

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F 623	Continued From page 13	F 623		

and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the 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

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F 623	Continued From page 14	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and 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

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F 623	Continued From page 15 relocation of the residents, as required at § 483.70(l). 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 notify the State Long-Term Care Ombudsman of a facility initiated transfer for one of 42 residents in the survey sample, Resident #82. The findings include: For Resident #82 (R82), the facility staff failed to notify the ombudsman of a facility-initiated transfer on 8/10/2023. The nurse's notes 8/10/2024 at 8:10 p.m. documented in part, "...Resident was noted with his left side of his face to the floor...When assessed, Resident was noted with swelling to his L. eye/L side of face, (2) Lacerations to L. Side temple/hair line area, L. eye red and swollen, C/O (complained of) L. shoulder/arm pain, Laceration to L. side of mouth...On call contacted and gave verbal order to send (R82) to hospital E.R (emergency room) for further evaluation and treatment. (Name of town) EMS (emergency medical services) contacted and transported (R82) to (Name of Hospital), R.P. (responsible party) made aware (name of RP) (Name of nurse practitioner) made aware and gave verbal order." A copy of the notice to the ombudsman for the transfer of 8/10/2023 was requested on 11/14/2023 at 11:37 a.m. A copy of the notice sent to the ombudsman for all of August 2023 facility-initiated transfers were	F 623	The ombudsman was notified of facility-initiated transfer for resident # 82 on 11/15/23. The Social Worker will complete an audit by 12/01/2023 of all discharges for the last 30 days to ensure the ombudsman was notified in writing to include the reason for discharge. The Administrator will in-service the Social Worker on transfer or discharge requirements to ensure that all appropriate residents are included by 12/08/2023. The Administrator or designee will run an admission to discharge/transfer report weekly for 4 weeks and then monthly for 2 months to ensure all transfers and discharges have been documented and the ombudsman notification is complete. The Administrator or designee will bring the results of the audits to the monthly QAPI meeting x 3 months or until compliance is achieved	

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F 623	Continued From page 16 reviewed. R82 was not on the list. An interview was conducted with OSM (other staff member) #1, the director of social services, on 11/14/2023 at 3:56 p.m. The notification documents sent to the ombudsman for transfers in August 2023 were reviewed with OSM #1. OSM #1 didn't know why it didn't populate (R82), she stated she just didn't know why. OSM #1 returned on 11/14/2023 at 4:43 p.m. and stated, R82 had a bed hold. OSM #1 further stated the resident wouldn't be considered a transfer in PCC (point click care-charting system) as he was holding the room. OSM #1 stated when she ran the report on 9/1/2023 he didn't show up because the room was reserved. When asked if a resident does a bed hold, then are you accurately reporting the discharged and transfers to the ombudsman, OSM #1 stated, she guesses not, there had to be a cliche in the computer system. The facility policy, "Transfer and Discharge Notice" documented in part, "6. A copy of the notice is sent to the Office of the State Long -Term Care Ombudsman at the same time as the transfer or discharge is provided to the resident and representative." ASM (administrative staff member) #1, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 5:04 p.m. No further information was provided prior to exit.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		12/30/23

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F 641	Continued From page 17 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure an accurate MDS (minimum data set) assessment for one of 42 residents in the survey sample, Resident #98. The findings include: For Resident #98 (R98), the facility staff failed to accurately code the discharge MDS assessment with the ARD (assessment reference date) of 10/25/2023, with the correct discharge location. R98's most recent MDS, a discharge assessment with an ARD of 10/25/2023, coded R98 as having a planned discharge on 10/25/2023 to a short term general hospital with a return to the facility not anticipated. The progress notes documented in part, - "10/17/2023 14:14 (2:14 p.m.) Note Text : SS (social services) and DT (director of therapy) spoke with Pt (patient) and Son about LCD (last covered day) of 10/24/2023 with a D/C (discharge) date of 10/25/2023. Pt and Son agreed, Son stated he would pick up Pt to take her home SS will set up home health PT has no preference. SS has sent referral to (Name of home health agency)." - "10/25/2023 11:00 (11:00 a.m.) Note Text : Pt stable for discharge home and has departed the facility."	F 641	The MDS Coordinator corrected the assessment for Resident #98 on 11/15/2023 to reflect that the resident transferred to another facility. Any resident that discharges has the potential to be affected by this deficient practice. The MDS Coordinator or designee will audit resident assessments of resident who discharged within the last 30 days to ensure their discharge status is reflected accurately. The audit will be completed by 12/8/2023 The Regional Director of Clinical Reimbursement or designee will provide education to the MDS department on the RAI manual section A2100 that reviews the medical record including the discharge plan and discharge orders for documentation of discharge location and to select the two-digit code that corresponds to the residents discharge status. The education will be completed by 12/8/2023 The MDS Coordinator or designee will audit discharge assessments for any resident that discharges or transfers weekly x four and then monthly x2 to ensure an accurate discharge status has been selected for the resident. The MDS Coordinator will bring the results of the	

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F 641	Continued From page 18 On 11/15/2023 at 8:47 a.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that they followed the RAI (resident assessment instrument) manual when completing the MDS resident assessments. She stated that when completing the discharge assessments for residents she reviewed the medical record documentation, used the information provided in the morning meetings, 24 hour report and communication from the nursing staff. RN #2 reviewed the discharge MDS for R98 with the ARD of 10/25/2023 and the progress notes and stated that the MDS stated the resident was discharged to the hospital and it looked like the progress notes documented the resident being discharged home. She stated that she would further review her notes and follow up. On 11/15/2023 at 9:10 a.m., RN #2 stated that they had reviewed R98's notes and MDS and felt that it was a data entry error. She stated that she had corrected the MDS to reflect the correct discharge location and provided a printed copy of the corrected MDS at that time. According to the RAI Manual, Version 1.16, dated October 2018, section A2100 documented in the steps for assessment to review the medical record including the discharge plan and discharge orders for documentation of discharge location and to select the two digit code that corresponds to the resident's discharge status. On 11/15/2023 at 9:37 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations were made aware of the findings.	F 641	audits to the monthly QAPI meeting x 3 months.	

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F 641	Continued From page 19 No further information was provided prior to exit.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		12/30/23

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F 656	Continued From page 20 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 staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for eight of 42 residents in the survey sample; Residents #12, #78, #90, #17, #73, #20, #5, and #62. The findings include: 1. For Resident #12, the facility staff failed to follow the comprehensive care plan to obtain weekly weights as ordered by the physician. The facility policy, "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident... 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...." A review of the comprehensive care plan	F 656	Care plans for residents #12, 78, 90, 17, 73, 20, 5 and 62 will be reviewed and revised on 12/08/2023. All residents with weight orders are at risk for this deficient practice. The MDS Coordinator or Designee completed a care plan audit on 12/08/2023 care plans were comprehensive and reflect residents current status The Director of Nursing or Designee will educate the Material Data Set nurses and licensed staff regarding the requirement of comprehensive care plans by 12/8/23. The Material Data Set Coordinator or Designee will audit 10 comprehensive care plans weekly x 4 weeks, then monthly x 2 months to ensure care plans are comprehensive and reflect resident current status. ¿ Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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revealed one dated 1/20/23 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 1/20/23 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

A review of the clinical record revealed a physician's order dated 5/10/23 for "Obtain weight weekly."

Further review of the clinical record revealed that there were no weights obtained during the following weeks (below dates run a Sunday through Saturday time frame):
Week of May 14 through May 20, 2023.
Week of May 21 through May 27, 2023.
Week of May 28 through June 3, 2023.
Week of June 4 through June 10, 2023.
Week of June 18 through June 24, 2023.
Week of July 2 through July 8, 2023.
Week of July 9 through July 15, 2023.
Week of July 16 through July 22, 2023.
Week of July 23 through July 29, 2023.
Week of July 30 through August 5, 2023.
Week of August 6 through August 12, 2023.
Week of August 27 through September 2, 2023.
Week of September 10 through September 16, 2023.
Week of September 17 through September 23, 2023.
Week of September 24 through September 30, 2023.
Week of October 1 through October 7, 2023.
Week of October 8 through October 14, 2023.
Week of October 15 through October 21, 2023.
Week of October 22 through October 28, 2023.

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Week of October 29 through November 4, 2023.

There was no evidence the resident refused to be weighed the above weeks.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done. She stated that if it was care planned and not done, then the care plan was not followed. She stated that the purpose of the care plan is everything you are supposed to do for the resident, their individualized needs.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.

2. For Resident #78, the facility staff failed to follow the comprehensive care plan to obtain weekly weights as ordered by the physician.

The facility policy, "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident... 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal

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representative, develops and implements a comprehensive, person-centered care plan for each resident...."

A review of the comprehensive care plan revealed one dated 11/21/22 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 11/21/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

A review of the clinical record revealed a physician's order dated 6/19/23 for "Obtain weekly weight every evening shift every Monday."

Further review of the clinical record revealed that there were no weights obtained on the Monday or any other day during the following weeks (below dates run a Sunday through Saturday time frame):
Week of July 2 through July 8, 2023.
Week of September 3 through September 9, 2023.
Week of September 17 through September 23, 2023.
Week of September 24 through September 30, 2023.
Week of October 1 through October 7, 2023.
Week of October 8 through October 14, 2023.

There was no evidence the resident refused to be weighed the above weeks.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to

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obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done. She stated that if it was care planned and not done, then the care plan was not followed. She stated that the purpose of the care plan is everything you are supposed to do for the resident, their individualized needs.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.

3. For Resident #90, the facility staff failed to follow the comprehensive care plan to obtain weekly weights as ordered by the physician.

The facility policy, "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident... 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...."

A review of the comprehensive care plan revealed one dated 12/5/22 for "The resident has alteration or potential for alteration in renal function..." This care plan included an

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intervention dated 12/5/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

A review of the clinical record revealed an order 6/7/23 for "Obtain weekly weight every night shift every Thursday for monitoring."

Further review of the clinical record revealed that there were no weights obtained on the Thursday or any other day during the following weeks (below dates run a Sunday through Saturday time frame):
Week of July 23 through July 29, 2023.
Week of October 22 through October 28, 2023.
Week of October 29 through November 4, 2023.

There was no evidence the resident refused to be weighed the above weeks.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done. She stated that if it was care planned and not done, then the care plan was not followed. She stated that the purpose of the care plan is everything you are supposed to do for the resident, their individualized needs.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made

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

4. For Resident #17, the facility staff failed to follow the comprehensive care plan to obtain weekly weights as ordered by the physician.

The facility policy, "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident... 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...."

A review of the comprehensive care plan revealed one dated 1/20/22 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 1/20/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

A review of the clinical record revealed a physician's order dated 6/1/23 for "Weight every day shift every Wednesday."

Further review of the clinical record revealed that there were no weights obtained on the Wednesday or any other day during the following weeks (below dates run a Sunday through

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Saturday time frame):
Week of July 23 through July 29, 2023.

There was no evidence the resident refused to be weighed the above week.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done. She stated that if it was care planned and not done, then the care plan was not followed. She stated that the purpose of the care plan is everything you are supposed to do for the resident, their individualized needs.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.

5. For Resident #73, the facility staff failed to follow the comprehensive care plan to obtain monthly weights as ordered by the physician.

The facility policy, "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident... 1. The interdisciplinary team (IDT), in conjunction with

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the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...."

A review of the comprehensive care plan revealed one dated 6/4/22 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 6/4/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

A review of the clinical record revealed a physician's order dated 5/10/23 for "Obtain weight monthly."

Further review of the clinical record failed to reveal any weights obtained for the month of June 2023.

There was no evidence the resident refused the weight for June 2023.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done. She stated that if it was care planned and not done, then the care plan was not followed. She stated that the purpose of the care plan is everything you are supposed to do for the resident, their individualized needs.

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On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.

6. For Resident #20 (R20), the facility staff failed to implement the resident's comprehensive care plan for medication administration to treat overactive bladder.

A review of R20's clinical record revealed a physician's order dated 7/10/23 for Gemtesa (1) 75 mg (milligrams)- one tablet by mouth in the morning for overactive bladder.

R20's comprehensive care plan dated 7/24/23 documented, "The resident has alteration or potential for alteration in renal function r/t (related to) BPH (benign prostatic hyperplasia), Diuretics, Kidney disease, Prostate enlargement, Overactive bladder. Interventions: Administer medications and treatments as ordered..."

A review of R20's September 2023 MAR (medication administration record) revealed the same physician's order for Gemtesa. On 9/4/23, 9/5/23, 9/6/23, 9/7/23 and 9/9/23, the MAR documented the code, "9= Other/ See Progress Notes." A nurse's note dated 9/4/23 documented, "Medication pending pharmacy." A nurse's note dated 9/5/23 documented, "Waiting on delivery from pharmacy." A nurse's note dated 9/6/23 documented, "Awaiting pharmacy delivery." A nurse's note dated 9/7/23 documented, "Waiting to be delivered by pharmacy." A nurse's note dated 9/9/23 documented, "Waiting for pharmacy to deliver."

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On 11/14/23 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated, "I know the care plan is there for us to check. Orders are put in, the care plan is updated, and everything is there for us to check to know how to take care of that person and everything that person needs." LPN #5 stated the nurses usually try to order medications six or seven days before they run out. LPN #5 stated that if a medication is not available for administration, the nurses should see if the medication is in the facility backup medication supply and if it is not, the nurses should notify the physician, possibly put a hold on the medication until it arrives from the pharmacy and let the pharmacy know they need the medication.

On 11/14/23 at 4:57 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) Gemtesa is used to treat overactive bladder. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a621015.html

7. For Resident #5, the facility staff failed to implement the comprehensive care plan for obtaining weights per the physician orders.

The comprehensive care plan dated, 4/3/2023, documented in part, "Focus: The resident has compromised cardiovascular conditions or is at risk for compromise r/t (related to) CHF (congestive heart failure), Diabetes, Hypertension (high blood pressure)." The "Interventions" documented in part, "Monitor weight...per

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routine/prn (as needed)/orders."

The physician order dated, 6/19/2023, documented, "Weight every evening shift, every Wed (Wednesday)."

Review of the clinical record failed to evidence documentation of the weights on the following Wednesdays:
7/5/2023
8/30/2023
9/13/2023
10/25/2023
11/1/2023.

On 11/14/2023, ASM (administrative staff member) #2, the director of nursing stated there were weights that were not obtained per the orders.

An interview was conducted with LPN (licensed practical nurse) #5, on 11/14/2023 at 4:15 p.m. When asked the purpose of the care plan, LPN #4 stated, the staff can look at it to see what is going on and what the patient needs. LPN #5 was asked if the care plan documents to get weights as ordered and the weights are not obtained as ordered, is that following the care plan, LPN #5 stated, no.

ASM #1, the administrator, ASM #2, and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 5:04 p.m.

No further information was obtained prior to exit.

8. For Resident #62 (R62), the facility staff failed to implement the comprehensive care plan to

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administer oxygen per the physician orders.

The comprehensive care plan dated, 4/9/2021, documented, "Focus: Resident has altered respiratory status or is at risk for breathing difficulty r/t (related to): COPD (chronic obstructive pulmonary disease), dependence on supplemental oxygen." The "Interventions" documented in part, "OXYGEN THERAPY: OXYGEN SETTINGS: O2 as ordered."

Observation was made of R62 on 11/13/2023 at approximately 1:30 p.m. The resident was sitting in her bed with her oxygen on via a nasal cannula (NC). The oxygen was set at 2.5 LPM (liters per minute). A second observation was made on 11/14/2023 9:10 a.m., the oxygen was in use by the resident and the setting was at 2.5 LPM.

The physician order dated, 5/10/2023, documented, "O2 (oxygen) at 3LPM via NC continuously."

On 11/14/2023 at 12:41 p.m. an observation was made of R62 with LPN (licensed practical nurse) #5. R62 had her oxygen in use. When asked to read the setting of the oxygen, LPN #5 stated it was set at 2.5 LPM. When asked what the prescribed rate was for R62, LPN #5 stated, the resident is supposed to be on 3 LPM. LPN #5 was asked how often should the oxygen setting be checked by the nurse, LPN #5 stated at least once a shift. When asked the purpose of the care plan, LPN #4 stated, the staff can look at it to see what is going on and what the patient needs. LPN #5 was asked if the care plan documents to administer oxygen per the physician order and it's not at the prescribed rate, is that following the care plan, LPN #5 stated, no.

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F 656	Continued From page 33 ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 3:31 p.m. No further information was provided prior to ext.	F 656		
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 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 staff interview, clinical record review and facility document review, it was determined that the facility staff failed to monitor residents weights per physician's orders for six of 42	F 692	1. The facility is unable to retroactively correct missing weights for residents #12, #78, #78, #90, #17, #73, # and #5.	12/30/23

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F 692	Continued From page 34 residents in the survey sample; Residents #12, #78, #90, #17, #73, and #5. The findings include: 1. For Resident #12, the facility staff failed to obtain weekly weights as ordered by the physician. A review of the clinical record revealed a physician's order dated 5/10/23 for "Obtain weight weekly." Further review of the clinical record revealed that there were no weights obtained during the following weeks (below dates run a Sunday through Saturday time frame): Week of May 14 through May 20, 2023. Week of May 21 through May 27, 2023. Week of May 28 through June 3, 2023. Week of June 4 through June 10, 2023. Week of June 18 through June 24, 2023. Week of July 2 through July 8, 2023. Week of July 9 through July 15, 2023. Week of July 16 through July 22, 2023. Week of July 23 through July 29, 2023. Week of July 30 through August 5, 2023. Week of August 6 through August 12, 2023. Week of August 27 through September 2, 2023. Week of September 10 through September 16, 2023. Week of September 17 through September 23, 2023. Week of September 24 through September 30, 2023. Week of October 1 through October 7, 2023. Week of October 8 through October 14, 2023. Week of October 15 through October 21, 2023. Week of October 22 through October 28, 2023.	F 692	2. The Director of Nursing or Designee completed an audit on 12/06/2023 to ensure weight orders are appropriately reflected in the resident orders 3. The Director of Nursing or Designee will educate nursing staff on obtaining weights as ordered by 12/08/23. Required weights are being communicated to nursing staff on a routine basis and entered into PCC. 4. The Director of Nursing or Designee will audit that weights are obtained as ordered weekly x 4 weeks, then monthly x 2 months. ¿ Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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Week of October 29 through November 4, 2023.

There was no evidence the resident refused to be weighed the above weeks.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done.

A review of the comprehensive care plan revealed one dated 1/20/23 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 1/20/23 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

The facility policy, "Weight Assessment and Intervention" was reviewed. This policy documented, "1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter..." The policy did not address obtaining weights per physician's orders, that may have a different frequency than the facility protocol of a monthly weight.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was

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provided by the end of the survey.

2. For Resident #78, the facility staff failed to obtain weekly weights as ordered by the physician.

A review of the clinical record revealed a physician's order dated 6/19/23 for "Obtain weekly weight every evening shift every Monday."

Further review of the clinical record revealed that there were no weights obtained on the Monday or any other day during the following weeks (below dates run a Sunday through Saturday time frame):
Week of July 2 through July 8, 2023.
Week of September 3 through September 9, 2023.
Week of September 17 through September 23, 2023.
Week of September 24 through September 30, 2023.
Week of October 1 through October 7, 2023.
Week of October 8 through October 14, 2023.

There was no evidence the resident refused to be weighed the above weeks.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done.

A review of the comprehensive care plan revealed one dated 11/21/22 for "The resident

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has alteration or potential for alteration in renal function..." This care plan included an intervention dated 11/21/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

The facility policy, "Weight Assessment and Intervention" was reviewed. This policy documented, "1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter..." The policy did not address obtaining weights per physician's orders, that may have a different frequency than the facility protocol of a monthly weight.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.

3. For Resident #90, the facility staff failed to obtain weekly weights as ordered by the physician.

A review of the clinical record revealed an order 6/7/23 for "Obtain weekly weight every night shift every Thursday for monitoring."

Further review of the clinical record revealed that there were no weights obtained on the Thursday or any other day during the following weeks (below dates run a Sunday through Saturday time

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frame):
Week of July 23 through July 29, 2023.
Week of October 22 through October 28, 2023.
Week of October 29 through November 4, 2023.

There was no evidence the resident refused to be weighed the above weeks.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done.

A review of the comprehensive care plan revealed one dated 12/5/22 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 12/5/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

The facility policy, "Weight Assessment and Intervention" was reviewed. This policy documented, "1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter..." The policy did not address obtaining weights per physician's orders, that may have a different frequency than the facility protocol of a monthly weight.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the

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Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.

4. For Resident #17, the facility staff failed to obtain weekly weights as ordered by the physician.

A review of the clinical record revealed a physician's order dated 6/1/23 for "Weight every day shift every Wednesday."

Further review of the clinical record revealed that there were no weights obtained on the Wednesday or any other day during the following weeks (below dates run a Sunday through Saturday time frame):
Week of July 23 through July 29, 2023.

There was no evidence the resident refused to be weighed the above week.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done.

A review of the comprehensive care plan revealed one dated 1/20/22 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 1/20/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing

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when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

The facility policy, "Weight Assessment and Intervention" was reviewed. This policy documented, "1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter..." The policy did not address obtaining weights per physician's orders, that may have a different frequency than the facility protocol of a monthly weight.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.

5. For Resident #73, the facility staff failed to obtain monthly weights as ordered by the physician.

A review of the clinical record revealed a physician's order dated 5/10/23 for "Obtain weight monthly."

Further review of the clinical record failed to reveal any weights obtained for the month of June 2023.

There was no evidence the resident refused the weight for June 2023.

On 11/15/23 at 9:11 AM, an interview was conducted with LPN #7 (Licensed Practical

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Nurse). She stated that if there is an order to obtain weights weekly or monthly, then it is expected that they are obtained unless the resident refuses. She stated that if it is not documented, then it was not done.

A review of the comprehensive care plan revealed one dated 6/4/22 for "The resident has alteration or potential for alteration in renal function..." This care plan included an intervention dated 6/4/22 for "Obtain weights per orders. Use same scale and preferably same time of day wearing same amount of clothing when obtaining weights. Report significant gain or loss to MD (Medical Doctor)."

The facility policy, "Weight Assessment and Intervention" was reviewed. This policy documented, "1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter..." The policy did not address obtaining weights per physician's orders, that may have a different frequency than the facility protocol of a monthly weight.

On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.
6. For Resident #5, the facility staff failed to obtain physician ordered weekly weights.

The physician order dated, 6/19/2023, documented, "Weight every evening shift, every Wed (Wednesday)."

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F 692	Continued From page 42 Review of the clinical record failed to evidence documentation of the weights on the following Wednesdays: 7/5/2023 8/30/2023 9/13/2023 10/25/2023 11/1/2023. On 11/14/2023, ASM (administrative staff member) #2, the director of nursing, presented some of the weights that were previously missing and stated, yes, there were weights that were not obtained per the orders. An interview was conducted with LPN (licensed practical nurse) #5 on 11/14/2023 at 4:16 p.m. When asked if there is a physician order for weekly weights, what actions should the nurse take, LPN #5 stated, the weights should be obtained per the physician order. The comprehensive care plan dated, 4/3/2023, documented in part, "Focus: The resident has compromised cardiovascular conditions or is at risk for compromise r/t (related to) CHF (congestive heart failure), Diabetes, Hypertension (high blood pressure)." The "Interventions" documented in part, "Monitor weight...per routine/prn (as needed)/orders." ASM #1, the administrator, ASM #2, and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 5:04 p.m. No further information was obtained prior to exit.	F 692		

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F 695	Continued From page 43	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide adequate respiratory care and services for three of 42 residents in the survey sample, Residents #77, #71, and #62. The findings include: 1. For Resident #77 (R77), the facility staff failed to store the resident's incentive spirometer (1) in a sanitary manner. A review of R77's clinical record revealed a physician's order dated 10/24/23 for an incentive spirometer. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/30/23, 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. On 11/13/23 at 1:04 p.m., R77 was observed	F 695	1. A covering for incentive spirometer for resident #77 was placed on 11/14/23. The nebulizer mask for resident #71 was stored appropriately on 11/14/23. The oxygen setting was corrected for resident #62 on 11/14/23. 2. The Director of Nursing or Designee completed an audit of all respiratory equipment on 12/06/2023 to ensure all items were covered and stored appropriately, and that all oxygen delivery systems were set as ordered. 3. The Director of Nursing or Designee will educate nursing staff on proper storage of respiratory equipment, and ensuring oxygen delivery systems are set to the appropriate flow rate as ordered by the physician by 12/8/23. 4.The Director of Nursing or Designee will audit 10 residents per week x 4 weeks, then monthly x 2 months to ensure respiratory equipment is properly stored,	12/30/23

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F 695	Continued From page 44 lying in bed. An uncovered incentive spirometer with the mouthpiece exposed to air was observed on the resident's overbed table. R77 stated the facility staff had not offered a cover for the incentive spirometer. On 11/14/23 at 8:22 a.m., the incentive spirometer remained uncovered and on the overbed table. On 11/14/23 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated incentive spirometers should be stored in a bag because germs can get on them. On 11/14/23 at 4:57 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 staff did not provide a specific policy regarding incentive spirometers. Reference: (1) The spirometer is a device used to help you keep your lungs healthy. Using the incentive spirometer teaches you how to take slow deep breaths. This information was obtained from: https://medlineplus.gov/ency/patientinstructions/000451.htm 2. For Resident #71 (R71), the facility staff failed to store the resident's nebulizer mask in a sanitary manner. A review of R71's clinical record revealed a physician's order dated 5/10/23 for albuterol sulfate (1) nebulization solution (1) 2.5 milligrams/3 milliliters 0.083%- one vial via nebulizer every six hours for wheezing and shortness of breath. On 11/13/23 at 1:25 p.m. and 3:56 p.m., R71 was	F 695	and that oxygen delivery systems are set to the appropriate rate. ¿ The results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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observed lying in bed. An uncovered nebulizer mask was observed on the resident's nightstand.

On 11/14/23 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated nebulizer masks should be stored in a bag because germs can get on them.

On 11/14/23 at 4:57 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, "Departmental (Respiratory Therapy)- Prevention of Infection" documented, "Store the circuit in plastic bag, marked with date and resident's name, between uses."

Reference:
(1) Albuterol sulfate is used to treat wheezing and shortness of breath. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682145.html

3. For Resident #62 (R62), the facility staff failed to administer oxygen at the physician prescribed rate of 3 LPM (liters per minute).

Observation was made of R62 on 11/13/2023 at approximately 1:30 p.m. The resident was sitting in her bed with her oxygen on via a nasal cannula (NC). The oxygen was set at 2.5 LPM. A second observation was made on 11/14/2023 9:10 a.m., the oxygen was in use by the resident and the setting was at 2.5 LPM.

The physician order dated, 5/10/2023, documented, "O2 (oxygen) at 3LPM via NC

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F 695	Continued From page 46 continuously." On 11/14/2023 at 12:41 p.m. an observation was made of R62 with LPN (licensed practical nurse) #5. R62 had her oxygen in use. When asked to read the setting of the oxygen, LPN #5 stated it was set at 2.5 LPM. When asked what the prescribed rate was for R62, LPN #5 stated, the resident is supposed to be on 3 LPM. LPN #5 was asked how often should the oxygen setting be checked by the nurse, LPN #5 stated at least once a shift. The comprehensive care plan dated, 4/9/2021, documented, "Focus: Resident has altered respiratory status or is at risk for breathing difficulty r/t (related to): COPD (chronic obstructive pulmonary disease), dependence on supplemental oxygen." The "Interventions" documented in part, "OXYGEN THERAPY: OXYGEN SETTINGS: O2 as ordered." The facility policy, "Oxygen Administration" documented in part, "7. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered...14. Monitor oxygen per MD order." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 3:31 p.m. No further information was provided prior to ext.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l)	F 698		12/30/23

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F 698	Continued From page 47 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to evidence communication with the dialysis center for one of one residents receiving dialysis services, Resident #82. The findings include: For Resident #82, the facility staff failed to ensure there was communication with the dialysis center each visit. The physician orders dated, 8/18/2023, documented, "Hemodialysis at (name of dialysis center) M, W, F (Monday, Wednesday, Friday) and time to be picked up 0900 (9:00 a.m.)." Review of the clinical record revealed the facility staff did not have the communication form, or the forms were missing communication information from either party (nursing facility or dialysis center) as follows: 9/4/2023 - no communication form 9/6/2023 - no communication documented from dialysis center on form. 9/8/2023 - no communication documented from dialysis center on form. 9/11/2023 - no communication documented from dialysis center on form. 9/13/2023 through 9/29/2023 - there was no	F 698	The facility is unable to retroactively correct the missing dialysis communication for resident #82. Any resident receiving dialysis is at risk for this deficient practice. On 12/01/23, communication forms between the dialysis center and the facility were audited since 11/13/2023 to ensure communication between the dialysis center and the facility were complete. The Director of Nursing or Designee will educate nursing staff on ensuring dialysis communication forms are initiated and sent to dialysis, and that the form is complete when resident returns from dialysis. Education will be completed by 12/8/23. The Director of Nursing or Designee will audit dialysis communication forms to ensure forms are present and completed weekly x 4 weeks, then monthly x 2 months. ¿ Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action	

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communication forms.
10/13/2023 - no communication documented from dialysis center on form.
10/16/2023 - no communication documented from dialysis center on form.
10/18/2023 - no communication documented from dialysis center on form.
10/20/2023 - no communication documented from dialysis center on form.
10/23/2023 - no communication documented from dialysis center on form.
10/25/2023 - no communication documented from dialysis center on form.
10/27/2023 - no communication documented from dialysis center on form.
10/30/2023 - no communication documented from dialysis center on form.
11/1/2023 - there was no communication form.
11/6/2023 - no communication documented from dialysis center on form.
11/10/2023 - there was no communication form.

The comprehensive care plan dated, 8/18/2023, documented in part, "Focus: The resident has alteration or potential for alteration in renal function...needs hemo (hemodialysis)." The "Interventions" documented in part, "Hemodialysis at (name of dialysis center) in (town of facility) on M, W, F at 9:30 a.m. to be picked up by (name of transport company) at 9:00 a.m."

An interview was conducted with LPN (licensed practical nurse) #5, on 11/14/2023 at 1:22 p.m. When asked what steps a nurse takes to send a resident out to a dialysis center, LPN #5 stated the staff get vital signs, and put them on the communication sheet and send the sheet with the resident. LPN #5 was asked when the resident

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returns, what do they do, LPN #5 stated they get a set of vital signs and review the communication form. LPN #5 stated many times the communication form is not filled in by the dialysis center.

An interview was conducted with RN (registered nurse) #3 on 11/14/2023 at 1:34 p.m. When asked the purpose of the communication form sent with the resident to dialysis, RN #3 stated it to let the dialysis center know the stability of the resident upon discharge from the facility and the dialysis center is to let us know how the resident did at dialysis.

The facility policy, "Dialysis Communication" documented in part, "Nursing facility and dialysis centers will have effective communication and collaboration related to resident care. 1. Any changes in condition of resident will be communicated to the dialysis center by facility staff. Any changes in condition that occurs during time at dialysis center will be communicated by telephone or communication form. 2. Any changes in physician/treatment orders or lab (laboratory) values will be communicated to dialysis center by facility staff by communication form or telephone. Any changes made my nephrologist/dialysis center or changes in lab values will be made by telephone or communication form."

ASM (administrative staff member) #1, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations, were made aware of the above concern on 11/14/2023 at 5:04 p.m.

No further information was provided prior to exit.

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F 698	Continued From page 50 (1) Hemodialysis filters your blood to rid your body of harmful wastes, extra salt, and water. This information was obtained from the following website: https://medlineplus.gov/dialysis.html.	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		12/30/23

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F 755	Continued From page 51 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 42 residents in the survey sample, Resident #20. The findings include: For Resident #20 (R20), the facility staff failed to ensure the medication Gemtesa (1) was available for administration on multiple dates in September 2023. A review of R20's clinical record revealed a physician's order dated 7/10/23 for Gemtesa 75 mg (milligrams)- one tablet by mouth in the morning for overactive bladder. A review of R20's September 2023 MAR (medication administration record) revealed the same physician's order for Gemtesa. On 9/4/23, 9/5/23, 9/6/23, 9/7/23 and 9/9/23, the MAR documented the code, "9= Other/ See Progress Notes." A nurse's note dated 9/4/23 documented, "Medication pending pharmacy." A nurse's note dated 9/5/23 documented, "Waiting on delivery from pharmacy." A nurse's note dated 9/6/23 documented, "Awaiting pharmacy delivery." A nurse's note dated 9/7/23 documented, "Waiting to be delivered by pharmacy." A nurse's note dated 9/9/23 documented, "Waiting for pharmacy to deliver." A review of the facility backup medication supply list revealed the medication Gemtesa was not available in the supply. On 11/14/23 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #5.	F 755	The medication for resident #20 was received from pharmacy on 09/10/2023. The resident had no negative outcomes from the missed doses of medication. All residents are at risk for this deficient practice. The Director of Nursing or designee completed an audit on 12/06/2023 to ensure that all residents have the ordered medications available. The Director of Nursing or Designee will educate licensed staff on the medication availability process. The process will be readily available at the nursing stations for reference. 4. The Director of Nursing or Designee will audit the missed medication report weekly x 4 weeks, then monthly x 2 months for any missed medications to ensure the process has been followed. ¿ Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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F 755	Continued From page 52 LPN #5 stated the nurses usually try to order medications six or seven days before they run out. LPN #5 stated that if a medication is not available for administration, the nurses should see if the medication is in the facility backup medication supply and if it is not, the nurses should notify the physician, possibly put a hold on the medication until it arrives from the pharmacy and let the pharmacy know they need the medication. On 11/14/23 at 4:57 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, "11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available." Reference: (1) Gemtesa is used to treat overactive bladder. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a621015.html	F 755		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		12/30/23

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F 756	Continued From page 53 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to develop a policy for monthly medication regimen reviews with times frames for the different steps in the process, including identifying the time frame in which the physician/nurse practitioner	F 756	1. The Drug Regimen Review policy was revised on 11/15/2023 to reflect the necessary time frames 2. The Director of Nursing completed an audit of the pharmacy recommendations	

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F 756	Continued From page 54 should respond to the recommendations from the consulting pharmacist for five of five residents included in the unnecessary medication reviews, Residents #71, #17, #22, #32, and #5. The findings include: Resident #71, #17, #22, #32, and #5's clinical records were reviewed for unnecessary medications. A review of the facility policy, "Medication Regimen Reviews" documented in part, "11. If the Physician does not provide a timely or adequate response, the Consultant Pharmacist identifies that no action has been taken, he/she contacts the Medical Director of (if Medical Director is the physician of record) the Administrator." The policy failed to include any documentation regarding the timeframe in which the physician must respond to the Consultant Pharmacist's recommendations. An interview was conducted with ASM (administrative staff member) #3, the vice president of clinical operations, on 11/14/2023 at 5:05 p.m. She presented a copy of the Medication Regimen Reviews policy and stated she added the words, "within 30 days" to the policy for the physician to respond. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations was made aware of the above findings on 11/15/2023 at 9:36 a.m. No further information was provided prior to exit.	F 756	for the month of November to ensure that the physician responded within the required timeframe on 12/01/2023. 3. The Director of Nursing or Designee will educate the Nursing Administrative team on the revised Drug Regimen Review policy by 12/8/23 4. The Director of Nursing or Designee will audit the pharmacy recommendations monthly x 3 months to ensure that recommendations are completed within the designated time frames. ¿ Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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F 758	Continued From page 55	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		12/30/23

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F 758	Continued From page 56 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 unnecessary psychotropic medications for one of 42 residents in the survey sample, Resident #71. The findings include: For Resident #71 (R71), the facility staff failed to attempt GDRs (gradual dose reductions) for the resident's use of Seroquel (1) and Cymbalta (2). R71 was admitted to the facility on 9/21/22. A review of R71's clinical record revealed the following physician's orders: 9/21/22- Seroquel 25 mg (milligrams)- two tablets every morning and at bedtime for depression. 11/21/22- Seroquel 25 mg- two tablets every morning and at bedtime for dementia with behavioral disturbance. 5/10/23- Seroquel 25 mg- two tablets in the morning and three tablets at bedtime for hallucinations. 9/21/22- Cymbalta 30 mg- one capsule in the evening for depression.	F 758	Resident #71 no longer resides at the facility. All residents who receive psychotropic medications have the ability to be affected by the deficiency. An audit was completed to ensure residents that receive psychotropic medications have a drug regimen review on 12/01/2023. All licensed staff will be educated to ensure residents who receive psychotropic medications receive medication appropriately by 12/08/2023. The Director of Nursing or designee will review weekly for two weeks and then monthly for two months that residents have had a drug regimen review.¿ Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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F 758	Continued From page 57	F 758		

11/21/22- Cymbalta 60 mg- one capsule every morning for major depression disorder.
12/14/22- Cymbalta 60 mg in the morning and 30 mg in the evening for major depressive disorder.
2/6/23- Cymbalta 60 mg in the morning and 60 mg in the evening for major depressive disorder.

A consultant pharmacist recommendation to the physician dated 5/16/23 documented, "Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter. This resident has been taking SEROQUEL 50 MG QAM (every morning) and SEROQUEL 75 MG QHS (every bedtime) since 11/21/22 without a GDR. Could we attempt a dose reduction at this time to SEROQUEL 50 MG BID (twice a day) to verify this resident is on the lowest possible dose? If not, please indicate response below." The physician's response was a check mark beside, "Use in accordance with relevant current standards of practice for psychiatric disorder."

A consultant pharmacist recommendation to the physician dated 9/29/23 documented, "Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood or treat psych disorder. This resident has been taking DULOXETINE (Cymbalta) 60 MG BID since 12/14/22 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below." The physician's response was a check

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F 758	Continued From page 58	F 758		

mark beside, "Continue this antidepressant therapy; dose reduction contraindicated due to: (blank space)."

Further review of R71's clinical record failed to reveal a GDR was attempted for the resident's use of Seroquel and Cymbalta, and failed to reveal a documented clinical rational why a GDR was contraindicated for the resident.

The nurse practitioners who signed the above pharmacy recommendations were no longer employed at the facility.

On 11/14/23 at 4:53 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated a GDR for antipsychotic medications and antidepressants should be attempted twice per year for the first year in two different quarters with one month in between, then annually after that. ASM #2 stated that if the physicians or nurse practitioners decide to not attempt a GDR, then they need to document and address why it isn't being attempted.

On 11/15/23 at 9:38 a.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Antipsychotic Medication Use" documented, "Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review."

References:
(1) Seroquel is used to treat schizophrenia and bipolar disorder. This information was obtained

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F 758	Continued From page 59 from the website: https://medlineplus.gov/druginfo/meds/a698019.html (2) Cymbalta is used to treat depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a604030.html	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in one of one facility kitchens. The findings include:	F 812	The identified sanitation concerns were corrected by the Dietary Manager on 11/14/2023 All residents have the potential to be affected by this deficient practice. The dry	12/30/23

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F 812	Continued From page 60 On 11/13/23 at 11:30 AM, the kitchen was inspected with OSM #5 (Other Staff Member) the Director of Dietary Services. The following items were noted: 1. A box of individual packages of animal crackers was on the floor in dry storage area. The box was open. 2. A baseball cap was on top of a box of thickened apple juice. 3. A large storage bin on wheels of thickener powder was left open with the bag of thickener also left open and exposed. There was no staff at the bin utilizing it. This bin was near the kitchen sink. 4. The stand mixer, which was clean and ready for use, and was covered, was stored next to meat slicer. The meat slicer was recently used for this day's lunch meal that was being prepared. It had been used to slice roast beef. A piece of roast beef (identified as such by OSM #5) was noted inside the mixing bowl of the stand mixer. On 11/14/23 at 2:47 PM, an interview was conducted with OSM #5 who stated that the animal crackers should not be on the floor. She stated that she addressed the ball cap that was on the thickened apple juice with the staff member, and that it should not be stored on top of food products. She further stated that personal items should not be in the kitchen area. Regarding the storage bin of thickener, she stated that staff took the lid off to wash it but it should not have been left open. Regarding the roast beef that was inside the mixing bowl of the stand mixer that was ready for use, she stated that she did not know how it got in the bowl because it had a cover over it.	F 812	storage area and food prep area will be audited by the Administrator to ensure that no sanitation concerns persist. The audits will be completed by 12/8/2023 The Dietary Manager will be educated by the Administrator on proper food storage, safe handling of food, and always maintaining clean food storage areas in accordance with the regulation The Food Services Manager will educate the dietary team on proper food storage, safe handling of food, and always maintaining clean food storage areas in accordance with the regulation. The education will be completed by 12/8/2023. The Food Service Manager or designee will audit the kitchen to ensure food is stored in a safe and sanitary manner, and that the floor is clear of any packaged food weekly x four and then monthly x 2. The Food Service Manager or designee will bring results of these audits to QAPI monthly x 3 months or until compliance is achieved.	

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F 812	Continued From page 61 The facility policy, "Food Receiving and Storage" was reviewed. This policy documented, "Foods shall be received and stored in a manner that complies with safe food handling practices....1. Food Services, or other designated staff, will maintain clean food storage areas at all times....6. Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and sprinkler heads, sewage/waste disposal pipes and vents...." The policy did not address the other identified concerns above. On 11/14/23 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Vice President of Clinical Operations were made aware of the findings. No further information was provided by the end of the survey.	F 812		
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;	F 842		12/30/23

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F 842	Continued From page 62 (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- (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	F 842		

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F 842	Continued From page 63 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, clinical record review and facility document review, it was determined the facility staff failed to provide complete and accurate documentation for two of 42 residents in the survey sample, Resident #301 and Resident #45. The findings include: 1. For Resident #301, the facility staff failed to evidence complete and accurate documentation for incontinence care, bathing, and weights. A review of the ADL (activities of daily living) document for September 2023 and October 2023 revealed September "Bathing" documentation missing for three of twelve shifts: 9/21, 9/22, and 9/29/23; October "Bathing" documentation missing from five of nine shifts: 10/2, 10/2, 10/3, 10/4, and 10/5/23. A review of the ADL document for September 2023 revealed September "incontinence" documentation missing from three of twelve-day shifts 9/21, 9/22 and 9/29/23; two of twelve evening shifts 9/29 and 9/30/23, and four of twelve night shifts 9/22, 9/23, 9/24, and 9/26/23. A review of the ADL document for October 2023	F 842	1.The facility is unable to retroactively correct ADL documentation for resident #301 and resident #45. 2. The Director of Nursing or Designee completed an audit of ADL documentation for showers and weights on 12/01/23 for the last 7 days 3. The Director of Nursing or Designee will educate nursing staff on the requirement of completing ADL documentation by the end of each scheduled shift by 12/8/23 4. The Director of Nursing or Designee will audit ADL documentation for completion weekly x 4 weeks, then monthly x 2 months. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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revealed October "incontinence" documentation missing from five of nine-day shifts 10/1, 10/2, 10/3, 10/4 and 10/5/23, two of eight evening shifts 10/1 and 10/3/23, and two of eight night shifts 10/1 and 10/3/23.

A review of the weights in the vital sign sheet and on the September TAR (treatment administration record) showed no missing weights. Weights were documented as done on the October TAR, with no evidence of the weight obtained either on the TAR or the vital sign sheet. Unable to locate manual/paper weight documentation.

An interview was conducted on 11/13/23 at 3:10 PM with CNA (certified nursing assistant) #1. When asked the process for providing incontinence care and bathing for the residents, CNA #1 stated, we round every two hours and perform incontinence care. We bathe/shower residents twice a week. If they are incontinent or get sweaty/dirty then they are bathed more frequently. This is documented on the CNA form. When asked what it means if incontinence care or showers/baths are not documented, CNA #1 stated, it means it was not documented, not that it was not done. When asked if this is a complete and accurate medical record if there is missing documentation, CNA #1 stated, no, it is not a complete and accurate medical record.

An interview was conducted on 11/14/23 at 8:30 AM with LPN (licensed practical nurse) #2, the unit manager. When asked about the missing documentation for Resident #301's bathing and incontinence care, LPN #2 stated they had a lot of agency aides at the time and the care was provided but not documented in PCC (point click care). LPN #2 stated they rounded on the

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residents and saw that care was being provided, the aides did not document it in PCC.

An interview was conducted on 11/14/23 at 1:30 PM with LPN #4, when asked about Resident #301, and if her signature was on 10/4/23 weight line on the October 2023 TAR, LPN #4 stated, "Yes, those are my initials. I do not why I did not put the weight in there." When asked the process for obtaining weights, LPN #4 stated, the CNAs write the weights on a sheet of paper and the nurses are to transcribe it into the medical record. She did not transcribe it. When asked if the medical record is complete and accurate, LPN #4 stated, no, there is no evidence of the weight. When asked if there are copies of the paper forms, LPN #4 stated, no.

An interview was conducted on 11/14/23 at 8:15 AM with CNA #3. When asked the process for obtaining resident weights, CNA #3 stated, see this paper form, the nurse highlights in pink the residents that need weights and in yellow the residents that need vital signs. We document on this form and the nurses enter the information in PCC.

On 11/14/23 at approximately 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations was made aware of the findings.

A review of the facility's "Charting and Documentation" policy revealed "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's

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medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."

No further information was provided prior to exit.

2. For Resident #45 (R45), the facility staff failed to maintain accurate ADL (activities of daily living) documentation for bathing/showers provided in August 2023 and October 2023.

The ADL (activities of daily living) documentation for R45 dated 8/1/2023-8/31/2023 documented in part, "ADL- Bathing (Prefers: Shower/Whirlpool)." Review of the ADL documentation failed to evidence a shower/bath documented on 8/11/2023 and 8/22/2023. The areas for documentation on these dates were observed to be blank.

The ADL documentation for R45 dated 10/1/2023-10/31/2023 documented in part, "ADL-Bathing (Prefers: Shower/Whirlpool)." Review of the ADL documentation failed to evidence a shower/bath documented on 10/17/2023 and 10/31/2023. The area for documentation on 10/17/2023 and 10/31/2023 was observed to be blank.

On 11/14/2023 at 10:35 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that personal hygiene and bathing were completed every shift. She stated that showers were given according to a schedule and were about every two days. She stated that R45 often refused their showers and preferred

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bed baths. She stated that when residents refused showers they offered them a second time later that day and then notified the unit manager and charge nurse if they still refused. She stated that they had shower caps that they used for residents who preferred bed baths to wash their hair. She stated that there was a shower aide employed by the facility Monday through Friday and they completed the scheduled showers. She stated that all care was documented every shift and there should not be any blanks in the ADL documentation. She stated that if there were blanks in the documentation the staff probably failed to document and they could not say that the care was not provided.

On 11/14/2023 at 1:44 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that R45 refused care often and often refused to get out of bed, refused to allow staff to brush their hair and refused showers. She stated that she had showers were twice a week and they attempted to get R45 to take them but they mostly refused.

On 11/14/2023 at 2:00 p.m., an interview was conducted with CNA #4. CNA #4 stated that they worked Monday through Friday as a shower aide and used a schedule for know which residents were scheduled for showers each day. She stated that R45 mostly refused to shower but would accept bed baths. She stated that baths and showers were documented in the computer in the ADL documentation by the assigned CNA and she documented the bath/shower on a paper shower sheet or resident list.

On 11/15/2023 at 8:42 a.m., an interview was conducted with LPN #2. LPN #2 stated that she

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F 842	Continued From page 68 had reviewed the paper shower/bath sheets and ADL documentation for R45 and was unable to find evidence a shower/bath on 8/11/2023, 8/22/2023, 10/17/2023 or 10/31/2023. She stated that they had a lot of agency staff in the building during that time and the documentation was not completed. She stated that the medical record was not complete and there was no excuse for not documenting the care provided or refusal of the care. On 11/15/2023 at 9:37 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations were made aware of the findings. No further information was provided prior to exit.	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,	F 880		12/30/23

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F 880	Continued From page 69 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 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.	F 880		

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F 880	Continued From page 70 §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 observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow infection control procedures during medication administration for two of four residents in the survey sample, Residents #60 and #88. The findings include: 1. For Resident #60 (R60), the facility staff failed to prepare medications in a sanitary manner during medication administration observation on 11/14/2023. On 11/14/2023 at 8:35 a.m., an observation was made of LPN (licensed practical nurse) #8 preparing medications for R60. LPN #8 was observed to prepare the following medications in a medication cup prior to taking them into R60's room for administration : - Norvasc 2.5mg (milligram) 1 tablet. - Buspar 15mg 1 tablet. - Celexa 40mg 1 tablet. - Lasix 20mg 1 tablet. - Risperidone 0.5mg 1 tablet. LPN #8 was observed to use her ungloved fingers to remove the Buspar 15mg, Celexa 40mg, Lasix 20mg and Risperidone 0.5mg tablets	F 880	1.LPN #8 was educated on 11/14/23 regarding preparing resident medications in a sanitary manner. Resident #60 and #88 was assessed by the Director of Nursing on 11/14/23 and no negatives outcomes were identified. 2. The Director of Nursing or Designee completed a medication pass observation with scheduled nurses on 12/06/23 to observe medication preparation 3. The Director of Nursing or Designee will educate licensed staff on preparing medications in a sanitary manner by 12/8/23 4. The Director of Nursing or Designee will complete 5 medication pass observations weekly x 4 weeks, then monthly x 2 months to ensure medications are prepared in a sanitary manner. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. 12/30/2023	

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from their packaging and place them into the medication cup.

On 11/14/2023 at 8:55 a.m., an interview was conducted with LPN #8. When asked about handling of tablets, LPN #8 stated that they should have put the pills directly into the medication cup from the packaging rather than handling them with their bare hands. She stated that it was a habit they had and they should not handle them to keep them clean.

A review of the facility policy, "Administering Medications" revised April 2019, documented in part, "...Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable..."

According to Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 568, "Administering Oral Medications: Procedure - 1. Wash hands. Rationale - Reduces transfer of microorganisms from hands to medication...Prepare selected medications ...c. Medications from a bingo card: Snap the bubble containing the correct medication directly over the medication cup. Do not touch the medication."

On 11/14/2023 at 3:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations were made aware of the findings.

No further information was provided prior to exit.

2. For Resident #88 (R88), the facility staff failed

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to prepare medications in a sanitary manner during medication administration observation on 11/14/2023.

On 11/14/2023 at 8:43 a.m., an observation was made of LPN (licensed practical nurse) #8 preparing medications for R88. LPN #8 was observed to prepare the following medications in a medication cup prior to taking them into R88's room for administration:
- Levetiracetam 1000mg (milligram) 1 tablet.
- Novolog 15U (units) via insulin syringe.
- Bumetanide 1mg 1/2 tablet.
- Escitalopram 10mg 1 tablet.
- Stool softener 100mg 1 tablet.

LPN #8 was observed to use her ungloved fingers to remove the Bumetanide 1mg 1/2 tablet, Escitalopram 10mg and Stool softener 100mg tablets from their packaging and place them into the medication cup.

On 11/14/2023 at 8:55 a.m., an interview was conducted with LPN #8. When asked about handling of tablets, LPN #8 stated that they should have put the pills directly into the medication cup from the packaging rather than handling them with their bare hands. She stated that it was a habit they had and they should not handle them to keep them clean.

On 11/14/2023 at 3:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations were made aware of the findings.

No further information was provided prior to exit.

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F 909	Continued From page 73	F 909		
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 observation, staff interview, and facility document review, the facility staff failed to conduct regular bed inspections for two of 42 residents in the survey sample, Residents #16 and #32. The findings include: 1. For Resident #16 (R16), the facility staff failed to conduct a regular bed inspection. A copy of the bed inspections was requesting during the entrance conference on 11/13/2023 at 11:20 a.m. On 11/13/23 at 1:20 p.m. and 11/14/23 at 8:28 a.m., R16 was observed in bed. On 11/15/23 at 9:17 a.m., an interview was conducted with OSM (other staff member) #6, the director of maintenance. OSM #6 stated the maintenance department has not completed bed inspections since before the pandemic. On 11/15/23 at 9:38 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2	F 909	Resident #32 no longer resides in the facility. Resident #16 had a bed inspection completed on 11/15/23. The facility developed and implemented a regular maintenance program to inspect bed frames, mattresses, and or bedrails to identify areas of possible entrapment, including separately purchased specialty mattresses and bed frames. All residents have the potential to be affected by this deficient practice. The Plant Operations Manager or designee will complete an inspection of all current bed frames, mattresses, and or bed rails to identify areas of possible entrapment. The audit will be completed by 12/8/23 The maintenance director will be educated by the Administrator regarding completion of routine bed safety inspections to ensure that there are no safety or entrapment issues. The education will be completed by 12/8/23. The Administrator or designee will audit	12/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA REHABILITATION AND HEALTHCARE CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

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F 909	Continued From page 74 (the director of nursing) were made aware of the above concern. The facility policy titled, "Bed Safety" documented, "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 promote the following approaches: a. 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..." 2. For Resident #32, the facility staff failed to conduct regular bed inspections. Observation was made of Resident #32 (R32) on 11/13/2023 at approximately 1:20 p.m. R32 was in bed with bilateral side rails in place. A copy of the bed inspections was requesting during the entrance conference on 11/13/2023 at 11:20 a.m. A second request was made on 11/14/2023 at 3:31 p.m. A third request was made on 11/14/2023 at 5:04 p.m. and again on 11/16/2023 at 8:00 a.m. On 11/15/2023 at 9:17 a.m., an interview was conducted with OSM (other staff member) #6, the director of maintenance. OSM #6 stated the maintenance department has not completed bed inspections since before the pandemic. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of clinical operations was made aware of the above findings on 11/15/2023 at 9:36 a.m.	F 909	TELS monthly x 3 months to ensure routine bed inspection documentation has been uploaded. The Administrator or designee will bring results of audits to the monthly QAPI meeting x 3 months. 12/30/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 909	Continued From page 75 No further information was provided prior to exit.	F 909		