STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495193		C 10/04/2023

NAME OF PROVIDER OR SUPPLIER
HENRICO HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
561 NORTH AIRPORT DRIVE
HIGHLAND SPRINGS, VA 23075

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E 000	Initial Comments	E 000		
	An unannounced Emergency Preparedness survey was conducted on 9/25/2023 through 10/4/2023. The facility was in substantial compliance with 42 CFR Part 483.73 Requirements for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey			
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 9/25/23 through 10/4/23. An extended survey was conducted 9/27/23 through 10/4/23. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.			
	Immediate Jeopardy was identified in the area of Freedom from Abuse, Neglect, and Exploitation at a Scope and Severity Level 4, pattern which constituted Substandard Quality of Care. After accepting and verifying the plan for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of level two, pattern.			
	Four complaints were investigated during the survey with findings as follows:			
	VA00059688=Substantiated with Deficiency VA00059493=Substantiated with Deficiency VA00059313=Substantiated with Deficiency VA00059202=Substantiated with Deficiency			
	The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/10/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 consisted of 48 resident reviews.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:	F 553		11/19/23

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F 553	Continued From page 2 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure the residents' right to participate in care planning for 1 resident, Resident #48, in a survey sample of 48 residents. The findings included: For Resident #48, the facility staff failed to provide the opportunity for her to participate in her own care planning. On 09/26/2023 at approximately 9:30 a.m., an interview was conducted with Resident #48, and she was asked if she participated in the planning of her care at the facility, to which Resident #48 replied, "I have never been asked or invited to attend any meetings about my care here, I would like to be involved." On 09/28/2023 at approximately 11:30 a.m., a review of Resident #48's clinical record was performed and revealed the most recent Minimum Data Set (MDS), a quarterly review with an Assessment Reference Date (ARD) of 08/24/2023, coded Resident #48 with a Brief Interview of Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. Resident #48 was documented as her own Responsible Party. Review of the clinical record also revealed a comprehensive care plan for Resident #48; however, there was no documentation indicating that Resident #48 was invited to participate with care plan meetings. There was an admission note dated 04/18/2023 that read, "Family notified about jumpstart [care plan] meeting, she [family	F 553	F553 Right to participate in Planning Care 1. Resident # 48 still resides in the facility. A care plan meeting scheduled and resident #48 and her RP (responsible party) were invited. 2. Current residents in the facility have the potential to be affected. An audit by Administrator or designee on all residents with upcoming quarterly or short-term care plans was conducted. Care plan invitation letters were completed and given to residents. To those residents with responsible parties listed, the facility□s administrative team ensured all letters were sent out by mail. All letters uploaded in PCC system and retained in a separate file. 3. The Administrator or designee will educate the facility social workers on ensuring residents and responsible party (RP) are receiving care plan notification letters, advising of date and time of care plan, mailing letters for approaching care plans. All letters are kept and uploaded into the PCC system for adequate documentation. 4. The Administrator or designee will complete weekly audits x 4 weeks then monthly x 2 months to ensure care plan participant letters are sent out in a timely manner and received by all residents; allowing residents and/or RP the opportunity to participate in their care plan. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no	

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F 553	Continued From page 3 member] said that she would be unable to attend..." On 10/2/2023 at approximately 1:30 p.m., an interview was conducted with the Facility Administrator and Regional Clinical Nurse (RCN) which included a review of Resident #48's clinical record. The RCN verified there was no evidence that Resident #48 had been invited to participate in her care planning since her admission on 04/13/2023. The Facility Administrator stated, "[Name redacted, Resident #48] should have been invited to attend any meetings about her plan of care, I expect those efforts to be documented in her clinical record and that has not been done." A facility policy was requested and received. The facility policy entitled, "Resident Assessment & Care Planning," effective date 11/01/2019, subheading "Procedure," item 7, read, "The MDS Coordinator or designee will be responsible for inviting the patient and the family to the conference utilizing the MFA Resident Care Planning Invitation form..." and item 9 read, "Notes will be kept for each patient's care plan discussed at the conference. A designated staff member attending the conference will include an electronic progress note summarizing the conference and stating all who attended, including the patient and any family members who were present." On 10/02/2023, the Facility Administrator was made aware of the findings. No further information was provided.	F 553	longer exist, the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		11/19/23

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F 561	Continued From page 4 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation the facility staff failed to ensure the resident's right to choose healthcare providers, for 1 resident, Resident #22, in a survey sample of 48 residents. The findings included:	F 561	F561 Self-determination 1. Resident #22 still resides in the facility. Resident #22□s pain management appointment was scheduled and informed of date and times of the appointment with transportation was arranged. Resident # 22 right to choose was honored with his	

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F 561	Continued From page 5 For Resident #22, the facility staff failed to schedule an appointment with the "Pain Management Clinic" as requested by the resident and ordered by the physician. On 09/25/2023 at approximately 3:00 p.m., Resident #22 requested to speak to this surveyor. Resident #22 had previously been interviewed about issues at the facility and wanted to add one more thing. The resident stated he had inquired with the Medical Director about pain medicine (Oxycodone) that he used to take and was discontinued, and wanting to restart that medication. Resident #22 stated the Medical Director told him it would be better if he would see a pain management clinic and wrote a referral to the pain management clinic in the chart. Resident #22 stated this happened "months ago," and he still has not been told about an appointment. A review of the clinical record revealed this was written in the progress notes by the physician on 07/28/2023. A review of the clinical record revealed the following progress note: "9/15/2023 2:57 pm -COMMUNICATION- Note Text: Spoke with resident and the MD explained to him that his paperwork had been faxed over to a pain management clinic on 9/11/23 and that I was waiting for a return call. I called on 9/15/23 to the pain management clinic and spoke with them and I was made aware that the paperwork had been received and that it is still under review, and they will call patient once the review is completed." On 09/26/2023 at approximately 10:30 a.m., an interview was conducted with Employee R, who	F 561	physician choice. 2. Current residents in the facility have the potential to be affected. An audit was conducted by the DON or designee to ensure all upcoming appointments were scheduled and transportation has been arranged. No other residents have requested to change health care provider. 3. The SDC or designee will educate all license nursing staff, unit secretary and discharge planners on the importance of ensuring physician orders for appointment or follow up appointment are scheduled timely with documentation. The physician, Resident and/or RP will be notified with documentation if delay in obtaining appointment. Resident rights will be honored to scheduled own appointments, assist with arranging transportation as needed. Residents have the right to choose healthcare provider and request to change physician will be accommodated with choice of other participating providers at the facility. 4. The Unit Manger or designee will complete weekly audits x 4 weeks then monthly x 2 months to verify resident□s right to choose healthcare providers have been honored and verify all resident appointments or follow up appointments per physician orders are scheduled or resident scheduled own appointment have transportation arranged, if delay in obtaining appointment the physician, resident and/or RP have documented notification. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no	

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F 561	Continued From page 6	F 561		
	schedules appointments for residents. She stated it was documented in her book where the appointment was requested on 09/11/2023. She stated she was aware that the appointment was requested in July; however, she had been out of work and did not get the original referral. Also, she did not know of the request until 09/11/2023 and she called the pain management clinic at that point. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.		longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		11/19/23

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F 565	Continued From page 7 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to act promptly upon the grievances arising from Resident Council. The findings included: Resident council continues to have complaints of the same nature with no improvement month after month. The facility has not effectively addressed the concerns of the residents regarding quality of food, timeliness of medication administration, timely incontinence care, poor staff attitudes, and cleanliness of the building. A review of the Resident Council minutes revealed the following: March 2023 - Residents complained that staff have bad attitudes, medication not given in a timely manner, CNAs not providing care to dependent residents routinely during the day and night. April 2023 - Staff are rude, staff are loud at night,	F 565	F565 Resident/Family Group and Response 1. The Administrator reviewed the grievances from the resident council meeting. A resident council meeting was held on 11/15/23 to discuss prior and current levels of professionalism, environmental services, dietary services, and care concerns. 2. Current residents in the facility have the potential to be affected. 3. The Administrator, or designee will educate the discharge planners, staff development coordinator , Director of Activities, Dietary Manager, Director of Environment and the Rehab Director and nursing managers on the grievance process with documentation appropriate follow-up for verification that concerns from resident council are addressed regarding staff professionalism, care concerns, environmental, pest control and dietary issues with resolution , at resident council meetings the prior	

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F 565	Continued From page 8 staff are using cell phones while providing incontinent or ADL care, diets are not being followed, and the dietary staff are rude. May 2023 - Floors, bathrooms, and sinks are not cleaned properly, alternate meals and/or sandwiches not offered, staff continue to be rude, no snacks offered at night, and retaliation of staff. June 2023 - Staff are loud at night, staff not checking/changing dependent residents, CNAs and nurses respond with "I don't have you" when asking for something, snacks not available at night, and CNAs not rounding. July 2023 - Food has not improved, staff continue to be rude, medications are unavailable or not ordered timely, and tray tickets do not match tray items. August 2023 - Medication times, rude staff, using phone while providing care, food items on tray do not match ticket, wrong diets served, and rooms and bathrooms had not been cleaned. On the afternoon of 09/28/2023, an interview was conducted with Employee S (Activities Director) who stated that each department is given the feedback from Resident Council to address within their department. When asked if she noticed the same issues keep arising month after month, she stated she did see a pattern. She also stated that all staff have been having education on customer service. The following are excerpts from a Facility Reported Incident that occurred on 04/27/2023. The incident was reported to the Office of Licensure and Certification by the facility	F 565	grievance/concerns reviewed to determine concerns resolved or plan for continued improvement required and any new concerns , Resident council concern areas will be included in the facility□s QAPI, to further discuss monthly during QA Committee meetings, action plans, grievances /concerns, reviewed, identify recurrent trends, improvement plan and education needs ,observation on rounds of concerns with revisions as needed. 4. The Administrator or designee will conduct audits weekly x4 weeks then monthly x 2 months audits to verify resident council grievances/concerns were addressed, completed and resident council has been informed of the resolution. The Administrator or designee will conduct 10 resident interviews weekly x 4 weeks then monthly x 2 months to assess new, improvements or resolved regarding resident concerns. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 565	Continued From page 9 Administrator: "[Resident name redacted] is an 84 year old resident with a BIMS [Brief Interview of Mental Status] of 15 [indicating no cognitive impairment]. H admitted to the facility on 3/3/23" "[Resident name redacted] alleged that CNA [name redacted] cursed at him saying "Kiss my ass!" after answering his call bell, left the room then returned repeating the same verbal allegation. "Based on the findings of the allegations regarding abuse/mistreatment regarding [Resident name redacted] and [CNA name redacted] substantiated. CNA [Name redacted] has been terminated. Staff will be educated on abuse and neglect." On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		11/19/23

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F 580	Continued From page 10 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff	F 580	F580 Notify of Changes	

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F 580	Continued From page 11 failed to notify the responsible party of a change in condition for 1 Resident, Resident #362, in a sample size of 48 Residents. The findings included: For Resident #362, facility staff failed to notify the responsible party/family of a change in his condition on 07/20/2023. On 10/02/2023 at approximately 3:00 p.m., Resident #362's clinical record was reviewed in its entirety with particular attention given to physician's orders, nursing assessments, and progress notes. A progress note dated 07/20/2023 at 7:34 p.m. documented, "Resident's daughter [name redacted] upset upon arrival to visit her father, nurse informed her residents blood pressure was elevated approx. noon time today, Resident pcp notified of elevation and medicated as directed, family was not notified of change in condition, daughter request that resident be transferred to hospital for evaluation, pcp notified of request, resident was taken to the ER via EMS." On 10/02/2023 at 4:15 p.m., the Clinical Nurse Consultant (CNC) was interviewed and stated, "It is my expectation and facility policy that both the doctor and family are notified if a resident experiences a change in their condition, always." Review of the facility policy titled, "Significant Change in Condition," with an effective date of 11/01/2019, "Procedure," item 4 read, "Responsible party will also be notified of a change in condition" and item 9, "Notification of responsible party shall be documented in the progress notes including time and name of	F 580	1. Resident #362 no longer resides in the facility. 2. Current residents in the facility have the potential to be affected. The DON or designee will conduct an audit on all current residents with changes in conditions since 10/4/2023 to verify RP has been notified. ` 3. The SDC or designee will educate all licensed nurses on the process for changes in condition with documented physician, resident as able and/or RP was notified timely from occurrence of the change in condition. 4. Unit Manager will conduct weekly audits x 4 weeks then monthly x 2 months to verify residents with change of conditions have RP notification. All findings will be reported to the QA Committee and the action plan will be revised as needed. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 580	Continued From page 12 person informed." On 10/02/2023 at the end of day meeting, the Facility Administrator and CNC were updated on the findings. No further information was provided.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582		11/19/23

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F 582	Continued From page 13 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to issue appropriate notices when skilled services were ending for 1 resident (Resident #87) in a survey sample of 3 residents, which were all reviewed for such notices. The findings included: For Resident #87, the facility staff failed to issue an Advance Beneficiary Notice (ABN) when skilled services were ending. On 09/25/2023, the facility Administrator was asked to provide a listing of residents who were discharged from Medicare Part A services. From this listing, a sample was selected which included	F 582	F582 Medicaid/Medicare Coverage/Liability Notice 1. Resident #87 still resides in the facility. The BOM informed the RP of the Advance Beneficial Notice (ABN). 2. All residents with a qualifying hospital stay and Medicare Part A benefit days available, have the potential to be affected by this deficient practice. An audit by the Regional MDS was conducted to identify if any current residents required an ABN for skilled services in the facility. 3. The Administrator will educate the Social Service /Director of Discharge Planner and Assistant Discharge Planner on the process for ensuring all skilled	

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F 582	Continued From page 14 Resident #87. The notices issued to these residents were reviewed and revealed the following: For Resident #87, the facility staff failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) notice prior to skilled care services ending. Only a Notice of Medicare Non-Coverage (NOMNC) was issued. Resident #87 was under skilled care with Medicare Part A as the primary payer from 06/11/2023 - 07/02/2023. Upon skilled care ending, Resident #87 remained a resident of the facility; therefore, should have been issued a SNF ABN in addition to the NOMNC. On 09/26/2023 at approximately 4:30 p.m., an interview was conducted with Employee O, the Discharge Planner. When asked to explain the purpose of the forms and when they are issued, Employee O said, "They are issued before insurance is cut, to let them know when insurance is going to stop and when copays will start." Employee O further explained that when a resident stays long-term care, both the NOMNC and ABN are issued. Employee O reviewed the notice for Resident #87 and confirmed that an Advance Beneficiary Notice should have been issued but was not. The facility policy titled, "Advanced Beneficiary Notice (ABN)" was reviewed. The policy read, "The Advanced Beneficiary Notice will be used to properly notify a Medicare Part A or Medicare Part B patient and/or responsible party of the clinical determination that the patient no longer meets the Medicare criteria for skilled services... 2. The Social Worker and Discharge Planner or	F 582	ABNs are given to skilled residents with services ending timely. The Business Office team has also received education on ensuring all ABNs are received, signed, and uploaded. 4. The Administrator or designee will conduct audits weekly x 4 weeks then monthly x 2 months for all residents receiving skilled services that are scheduled to end, to ensure the ABN are received by residents or the RP. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 582	Continued From page 15 designee issues the notice to the beneficiary or their representative in person or by telephone of the upcoming non-coverage status based on clinical team recommendations. a. This notification must be made at least 2 days in advance of non-coverage status for Part A recipients..." In the CMS document, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)," the instruction sheet reads, "...The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A) ..." Accessed online at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNF-ABN- On 09/26/2023 during the end of day meeting, the facility's Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		11/19/23

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F 584	Continued From page 16 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a safe, clean, comfortable, and homelike environment for residents residing on 2 of 2 units, and for Resident #363.	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. Residents #363 no longer resides in the facility. Resident #19 still resides in the facility and pest control treated the room. The pest control team was notified	

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F 584	Continued From page 17 The findings included: 1. For the facility, residents the staff failed to maintain clean shower rooms on 2 of 2 units and failed to control pests, such as bedbugs and roaches. On 09/26/2023 at 2:00 p.m. during the Resident Council meeting, the 6 residents (all the residents on that unit) present stated the shower rooms "are filthy, who wants to shower in those rooms?" Resident #42 stated she would rather sponge bathe daily than use the shower rooms and the other 5 participants agreed. Observations were made of the shower rooms on 09/26/2023. On 09/27/2023 and 09/29/2023, the shower rooms were not clean, and the shower stalls had orange and black stains. The shower chairs had brown stains and the floor needed repair in the North shower room. On 09/26/2023 at approximately 3:30 p.m., an interview was conducted with CNA D who was asked if she knew what the black and orange stains were in the shower stalls. CNA D stated that she thought the black stains might be dirt. When asked how often the shower stalls were cleaned, she stated that "Housekeeping cleans the shower rooms, but we use the wipes and wipe down the shower chairs between each resident." From 09/25/2023 through 10/04/2023, fruit flies as well as house flies were sighted throughout the facility in residents' rooms on both units, and in the dining room. On 09/29/2023 at approximately 1:15 p.m.,	F 584	and exterminated all areas identified. The pest control team did a follow-up visit regarding the bed bugs and rooms identified, there were no other concerns of bed bugs. Shower rooms on both units were detailed clean, all identified floor tiles will be replaced. 2. Current residents in the facility have the potential to be affected. An audit by the maintenance director was conducted to identify other floor tiles that required repair, and none noted. Any other pest sightings were treated by the pest control vendor. The director of environmental services observed shower rooms on both units to verify cleaning and was maintained. 3. The Regional Director of Maintenance educated the Maintenance Director on the process of pest control, review of pest control book, bed bug management and maintenance repairs, with follow-up to ensure all areas of concerns are resolved. The Director of Environmental Services educated all housekeepers on the cleaning process and scheduling for both shower rooms. The SDC will educate the facility staff on ensuring all and any pest control services are logged in the Pest Control book and work orders submitted for maintenance repairs. Any concerns with the cleanliness of shower rooms or resident rooms need to be reported to the Director of Environmental Services. Furniture in resident rooms include a chair. 4. The Maintenance Director or designee will conduct audits weekly x 4 weeks then monthly x 2 months to review	

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F 584	Continued From page 18 Surveyor E entered Resident #19's room with CNA D, and when the cabinet door and drawer were opened cockroaches ran out (approximately 5-10 insects) and were all over the sides and top of the bedside cabinet. A review of the pest control log revealed that on 08/04/2023 room numbers 32, 37, and 54 were treated for bed bugs; however, no follow-up treatment was done to ensure any eggs that have hatched were treated for, which is standard practice for bedbug treatment. On 09/28/2023, the resident in Room #8 was complaining of itching, and stated he had bed bugs. The facility did treat that room on 09/29/2023. On 10/04/2023 during the end of day meeting the Administrator was made aware of the findings. No further information was provided. 2. For Resident #363, the facility staff failed to provide a chair in her room at her request. On 09/26/2023 at approximately 9:30 a.m., Resident #363 was observed sitting on her bed in her room. An interview was conducted and Resident #363 stated, "I have asked constantly for a chair to be put in my room since I got here a couple of weeks ago because my husband has no where to sit when he comes to visit me. He comes to see me every day and has to sit in my wheelchair; I'm not asking for much, just a chair. He should not have to use my wheelchair to be comfortable while he visits, it makes no sense at all." Resident #363's wheelchair was observed at the foot of her bed, and there was no chair in her	F 584	pest control book to verify pest sightings were treated and if follow up required was completed and observe shower room floor tiles to ensure both shower rooms are operable with no other broken floor tiles and review work orders for repairs and completion. The Director of Environmental Services or designee will conduct weekly x4, then monthly x2 months to verify both shower rooms are cleaned and as needed, and a chair is available in room for each resident. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 5. Date of compliance: 11/19/2023	

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F 584	Continued From page 19 room. On 09/27/2023 at approximately 10:30 a.m., a group interview was conducted with the Facility Administrator and the Clinical Nurse Consultant (CNC), both of whom stated that it was expected for a chair to be placed in a resident's room as part of the regular room set up or at minimum, a chair would be provided upon the resident's request. No further information was provided.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility failed to protect the residents' right to be free from physical abuse and sexual abuse by a staff member and failed to protect the residents from continued abuse by their	F 600	F600 Free from Abuse and Neglect 1. Resident #53 and resident #85 no longer reside in the facility. The identified agency CNA assigned to both residents since allegations on 8/10/2023 has not	11/19/23

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F 600	Continued From page 20	F 600		

perpetrator, affecting 2 residents (Resident #53 and #85) in a survey sample of 48 residents, which resulted in psychosocial harm for Resident #53.

The findings included:

1. For Resident #53, the facility staff failed to protect the resident from enduring physical and sexual abuse, which resulted in psychosocial harm for the resident.

On 09/26/2023, during a clinical record review of Resident #53's clinical chart the following was noted:
a. Resident #53 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.
b. A progress note dated 08/10/2023 at 5:06 p.m., stated, "Patient sent to Saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer."
c. Another progress note dated 08/10/2023 at 5:15 p.m., read, "Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges."

On 09/27/2023, a review was conducted of the facility's investigation that had been performed. There was a written statement that was taken from Resident #53 that read as follows:
"Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his

worked at the facility, FRIs were submitted for both residents #53 and #85 with investigation on 9/27/2023.
2. Current residents in the facility have the potential to be affected. Residents were interviewed, with no concerns of any form of abuse. The facility also performed skin assessments on all residents that could not be interviewed., no areas form of abuse were identified.
3. The SDC will provide education to all facility staff on resident right to be free from any type of abuse, the abuse policies, and procedures regarding protecting resident and/or residents, reporting to Administrator or DON, and submitting Facility Reported Incident includes appropriate state agencies, and investigation process, protecting the residents from any type of abuse. Any staff identified in an allegation of abuse will be suspended pending investigation immediately upon knowledge to protect the resident or other residents from potential abuse and/or emotional harm.
4. The SDC or designee will conduct audits weekly x 4 weeks then monthly x 2 months on new hires to verify Abuse and Neglect training completed during their orientation period. The Administrator or designee will audit weekly x 4 weeks then monthly x 2 months to review any service concerns to identify any type of allegations of abuse/neglect to ensure resident or residents were protected, the alleged staff member was immediately suspended pending upon knowledge a FRI report is submitted, and the investigation process followed and completed. Results of the

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F 600	Continued From page 21 face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist." On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, "On 8/10 when I came in, the speech therapist (SLP) came and talked with me 8:30 a.m., and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, she identified as [CNA C's name redacted]. I asked him [Resident #53] if he wanted to be sent out, he said yes." The DON stated that she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the Speech Language Pathologist (SLP). The SLP reported	F 600	review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 600	Continued From page 22 on 08/10/2023, she arrived to work at 7:50 a.m., and as she walked down the hall, Resident #53 got her attention and reported, "the aide [CNA C] had put a washcloth on his face and he had touched his penis. I told the nurse." The SLP also stated that at about 9:30 a.m., she saw Resident #53 in the dining room being fed by the CNA who had allegedly abused Resident #53 earlier that morning. The SLP said, "I saw his [Resident #53] mouth was stuffed full of food, and I saw that was way too much and he [CNA C] was getting ready to put more in his mouth. I had the resident spit it out and said that's why too much and it was the wrong diet texture, he [CNA C] said that's what they sent. I had to take over feeding the resident." The SLP reported that she reported this incident to nursing leadership and her immediate supervisor. Later that day she saw CNA C still in the facility/in passing in the hall. She was not sure of the time. The SLP said she reported the events to the Director of Nursing (DON) and wrote a statement regarding the events involving Resident #53 and CNA C. Surveyors D and F attempted to interview Resident #53 the same day, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There was no change in his report. The resident became very tearful and stated he was so afraid and that CNA C "laid me flat in the chair on my back and was trying to silence me and say I choked on food." Resident #53 said, "[Employee M's name redacted] took a picture." The resident stated that following this incident he was afraid to sleep, kept looking around, and had to be	F 600		

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F 600	Continued From page 23 prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, "Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time." This was harm. An additional review of the clinical record revealed that Resident #53 was ordered Trazodone 50 mg tablet to be given at bedtime for sleep aid on 08/23/2023. On the afternoon of 09/29/2023, an interview was conducted with the scheduler, who stated that on the afternoon of 08/10/2023, she was told by the Director of Nursing to send CNA C home, due to "complaints and work performance." Review of payroll records revealed that CNA C did not clock out and leave the premises on 08/10/2023 until 1:17 p.m. A review was conducted of the facility's abuse policy titled, "Abuse/Neglect/Misappropriation/Crime/Administrative Reference Guide." Excerpts from this policy read, "1. Physical abuse: b. physical contact intentionally or through recklessness that results in, or is likely to result in, death, physical injury, pain, or psychological harm to the patient. Indications of psychological harm include a noticeable level of fear, anxiety, agitation, or emotional distress in the patient. 3. Sexual Abuse: a. sexual harassment, inappropriate touching." The policy titled, "Abuse/Neglect/Misappropriation/Crime/ Patient Protection," was reviewed. This policy read, "There is a zero tolerance for mistreatment,	F 600		

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F 600	Continued From page 24	F 600		

abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. 1. Patients of the center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment. 2. Any employee and/or covered agent of the Center, who willfully abuses or participates in any criminal activity against any patient of the center will be immediately subjected to corrective action."

On 09/27/2023 and 09/28/2023, the facility Administrator and corporate staff were made aware of the above findings. On 09/27/2023, the corporate staff notified the survey team they would be re-opening the investigation into the events involving Resident #53 and CNA C.

No further information was provided.

2. For Resident #85, the facility staff failed to ensure the resident's right to be free from sexual abuse.

On 09/26/2023, an interview was conducted with Resident #103, who stated she knew that on 08/10/2023 Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85. According to the audio recording, CNA E could be heard saying, "Why did you let that man shave you down there." Resident #85 stated that she did not let anyone shave her to which you can hear the CNA reply "You are mighty bald down there. You got less hair than me and I was waxed."

On 09/27/2023 at 1:00 p.m., an interview was

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F 600	Continued From page 25 conducted with CNA E who admitted that she had knowledge of the incident and that she made the nurse on duty and the DON aware of the incident. On 09/27/2023 an interview was conducted with the DON who stated she did not view it as abuse and stated. "Coming from [Resident #103] she was not inclined to believe her." When asked what she was supposed to do with allegations of abuse, she stated she should investigate them. When asked what she should do first, she repeated "Investigate them." The DON was advised that facilities are to report first and complete the investigation is second. The DON was also advised to review the facility's policy and the State Operations Manual (SOM) on abuse reporting. The incident was not reported nor investigated until 09/27/2023 (2 days after the survey began). The incident was reported to the Office of Licensure and Certification, Adult Protective Services, the Department of Health Professions, and the Police by the Regional Director of Clinical Services. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		11/19/23

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F 607	Continued From page 26 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy affecting 2 residents (#53 and #85), resulting in harm for Resident #53. Immediate Jeopardy (IJ) was identified on 09/27/2023 at 5:25 p.m., at which time the facility Administrator and Director of Nursing were made aware. Following verification of the removal of immediacy, the facility abated IJ on 10/04/2023 at 10:45 a.m. The scope and severity was lowered to a level 3, pattern.	F 607	F607 Develop/Implement Abuse/Neglect Policies 1. Resident #53 and resident #85 no longer reside in the facility. The identified agency CNA assigned to both residents since allegations on 8/10/2023 has not worked at the facility, FRIs were submitted for both residents #53 and #85 with investigation on 9/27/2023. Employee #4, #10, #13, #24 has not returned to the facility and were termed from the facility.	

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F 607	Continued From page 27 The findings included: 1. The facility staff failed to implement their abuse policy by permitting facility staff to work when their criminal background status was unknown. On 09/27/2023, a review was conducted of a sample of employee files which revealed the following: a. Staff #4 was hired 03/17/2022 and terminated employment on 10/01/2022. Staff #4's employee record had no evidence that a criminal background check had been obtained. Therefore, from 03/17/2022 - 10/01/2022, facility staff were unaware of Staff #4's criminal background status, and the staff member provided direct resident care during this time. b. Staff #10 was hired on 10/31/2022 and terminated employment on 01/10/2023. There was no evidence provided to indicate that Staff #3 had a criminal background check performed. Therefore, from 10/31/2022 - 01/10/2023, facility staff were unaware of Staff #10's criminal background status and was permitted to provide direct care to residents. c. Staff #13 was hired 07/5/2022 and terminated employment on 10/08/2022. Staff #13's employee record had no evidence of a criminal background check on file. Therefore, from 07/05/2022 - 10/08/2022, facility staff were unaware of Staff #13's criminal background status and was permitted to provide direct care to residents. d. Staff #24 was hired 03/08/2023. Staff #24's criminal background check was requested on	F 607	2. Current residents in the facility have the potential to be affected. An audit of all criminal background checks was completed by the HR Director and Regional HR support on all current staff had background checks Any staff providing direct patient care that did not have a criminal background check on file was immediately removed from the schedule. Resident interviews were conducted to identify any allegations of abuse and residents that could not be interviewed had skin assessments performed with no findings. Resident # 103 reported allegation of abuse by an employee, the abuse policy followed, employee suspended pending investigation, resident protected, FRI submitted with appropriate state agencies and investigation with supporting documentation completed. 3. The Regional HR Director and Regional Director of Clinical Operations held a mandatory training with the Administrator, HR Director and Department Managers on the hiring process, screening new and prior hires employees with review of prior employment and must have a Virginia State Police criminal background check returned, reviewed for barrier crimes prior to employee work with direct resident care. SDC or designee educated all facility staff on the abuse policies and procedures regarding protecting resident and/or residents, reporting to Administrator or DON, and submitting Facility Reported Incident (FRI) includes appropriate state agencies, and	

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F 607	Continued From page 28 03/07/2023 and noted to read, "Transaction is being processed" and the final report was not on file. Therefore, from 03/08/2023 until the time of survey, the facility staff were unaware of Staff #24's criminal background status and the employee was permitted to continue to work without knowing if the employee was guilty of a barrier crime. On 09/27/2023 at approximately 1:00 p.m., an interview was conducted with the Human Resources Director (HRD) who stated, "We get criminal background checks on every applicant. For the Virginia State Police, we wait 30 days, and they can work with another employee while we wait for it." The HRD verified that Staff #4, #10, #13, and #24 did not have a criminal background report within 30 days of their respective hire dates. A review of the facility's policy entitled, "Abuse/Neglect/Misappropriation/Crime Prevention/Screening/Training," dated 01/23/2020, subtitle, "Procedure," item 1 read, "Criminal background and reference checks are performed on all employees." Prior to conclusion of the survey, the facility staff provided the survey team with a facility policy entitled, "Onboarding/Virginia," with an effective date of 10/01/2023, which was reviewed. This policy read, "The company will comply with all local and state regulations and guidelines as required for all employees who are employed in the Commonwealth of Virginia. 1. A complete and accurate personnel file, as outlined in Policy #207 and in accordance with 12VAC5-371-140-E of the Administrative Code of Virginia, will be	F 607	investigation process, protecting the residents from any type of abuse. Any staff identified in an allegation of abuse will be suspended pending investigation immediately upon knowledge to protect the resident or other residents from potential abuse. and/or emotional harm. Investigation includes documented and retain copies in FRI folder of resident interviews, staff statements and any other documents that supports findings of investigation. 4. The Administrator or designee will conduct audits weekly x 4 then monthly x 2 months on all new hires or rehires to ensure the VA criminal background checks are received prior to the onboarding process and employee working. The Administrator or designee will audit weekly x 4 weeks then monthly x 2 months to review any service concerns to identify any type of allegations of abuse/neglect to ensure resident or residents were protected, the alleged staff member was immediately suspended pending upon knowledge a FRI report is submitted, and the investigation process followed and completed ,the investigation includes documented and retain copies in FRI folder of resident interviews, staff statements and any other documents that supports findings of investigation. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 607	Continued From page 29 created for each new employee which contains the basic demographic and indicative data needed for employment, as well as: a. A criminal history check of the Central Criminal Records Exchange conducted via Virginia State Police Non-Criminal Justice Interface (NCJI) in accordance with 32.1-126.01 of the Code of Virginia..." 2. For Resident #53, the facility staff failed to prevent the resident from being abused by a staff member. After being made aware of the allegation, the facility staff failed to take measures to protect the Resident #53 from their alleged perpetrator, which permitted the staff member to abuse the resident again. On 09/26/2023, during a clinical record review of Resident #53's clinical chart, the following was noted: a. Resident #53 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. b. A progress note dated 08/10/2023 at 5:06 p.m. stated, "Patient sent to Saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer." c. Another progress note dated 08/10/2023 at 5:15 p.m. read, "Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges."	F 607		

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F 607	Continued From page 30 On 09/27/2023, a review was conducted of the facility's documentation regarding the events involving Resident #53. There was a written statement taken from Resident #53 that read, "Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist." On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, "On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 a.m., and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, she identified as [CNA C's name redacted]. I asked him [Resident #53] if he wanted to be sent out, he said yes." The DON stated she had CNA C sent home prior to her arrival at the facility early that	F 607		

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F 607	Continued From page 31 morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. However, it was later determined that CNA C had not been removed from the premises until over 5 hours following the initial incident. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the Speech Language Pathologist (SLP). The SLP reported on 08/10/2023, she arrived to work at 7:50 a.m., and as she walked down the hall, Resident #53 got her attention and reported, "the aide [CNA C] had put a washcloth on his face and he had touched his penis. I told the nurse." The SLP stated at about 9:30 a.m. in the dining room, she saw Resident #53 being fed by the CNA who had allegedly abused the resident earlier that morning. The SLP said, "I saw his [Resident #53] mouth was stuffed full of food, and I saw that was way too much and he [CNA C] was getting ready to put more in his mouth. I had the Resident spit it out and said that's why too much and it was the wrong diet texture, he [CNA C] said that's what they sent. I had to take over feeding the Resident." The SLP reported that she reported this incident to nursing leadership and her immediate supervisor. Later that day, she saw CNA C still in the facility/in passing in the hall. She was not sure of the time. The SLP said she reported the events to the Director of Nursing and wrote a statement regarding the events involving Resident #53 and CNA C. On 9/27/23, Surveyors D and F attempted to interview Resident #53, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There	F 607		

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F 607	Continued From page 32 was no change in his report. The resident became very tearful and stated he was so afraid and that CNA C "laid me flat in the chair on my back and was trying to silence me and say I choked on food." Resident #53 said, "[Employee M's name redacted] took a picture." The resident stated that following this incident he was afraid to sleep, kept looking around, and had to be prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, "Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time." This was harm. An additional review of the clinical record revealed that Resident #53 was ordered Trazodone 50 mg tablet to be given at bedtime for sleep aid on 08/23/2023. On the afternoon of 09/29/2023, an interview was conducted with the scheduler, who stated on the afternoon of 08/10/2023, she was told by the Director of Nursing to send CNA C home, due to "complaints and work performance." Review of payroll records revealed that CNA C did not clock out and leave the premises on 08/10/2023 until 1:17 p.m. A review was conducted of the facility's abuse policy titled, "Abuse/Neglect/Misappropriation/Crime/Administrative Reference Guide". Excerpts from this policy read, "1. Physical abuse: b. physical contact intentionally or through recklessness that results in, or is likely to result in, death, physical injury, pain, or psychological harm to the patient. Indications of psychological harm include a noticeable level of fear, anxiety, agitation, or	F 607		

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F 607	Continued From page 33 emotional distress in the patient. 3. Sexual Abuse: a. sexual harassment, inappropriate touching." The policy titled, "Abuse/Neglect/Misappropriation/Crime/ Patient Protection," was reviewed. This policy read, "There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. 1. Patients of the center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment. 2. Any employee and/or covered agent of the Center, who willfully abuses... or participates in any criminal activity against any patient of the center will be immediately subjected to corrective action." 3. For Resident #53, the facility staff failed to report and investigate allegations of abuse. On 09/27/2023, a review was conducted of the facility's documentation of the allegation and actions taken regarding Resident #53 and the incidents with CNA C. There was a written statement taken from Resident #53. There was also a written statement from Employee M, the Speech Language Pathologist (SLP). Lastly there was evidence the state survey agency/Office of Licensure and Certification (OLC) and Adult Protective Services (APS) were faxed a report of the incident on 08/10/2023 at 7:10 p.m. There was no evidence that an investigation into the allegations was conducted. The report submitted to the OLC and APS lacked significant information regarding Resident #53's allegations involving CNA C. The details of being	F 607		

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awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair, and the details of the aggressive feeding were all omitted from the report.

On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility's Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, "On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 a.m. and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day," which she identified as [CNA C's name redacted]. "I asked him [Resident #53] if he wanted to be sent out, he said yes." The DON stated that she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53.

During the above interview, the DON was asked to explain what steps were taken to investigate the allegation and if she had any additional documentation regarding an investigation. The DON stated she had interviewed other residents and reviewed the hospital records of Resident #53. Because there was no forensic evidence, she unsubstantiated the allegation. The DON was asked to provide evidence of the resident interviews she conducted, and she said she had

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F 607	Continued From page 35 nothing to provide. When asked if staff, including but not limited to CNA C, were interviewed, the DON indicated none of the staff were interviewed. The facility had no evidence of any investigation being conducted. A review was conducted of the facility's abuse policy titled, "Abuse/Neglect/Misappropriation/Crime/Reporting Requirements/Investigations." Excerpts from this policy read, "2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations." Immediate Jeopardy (IJ) was identified on 09/27/2023 at 5:25 p.m., at which time the facility's Administrator and Director of Nursing were made aware. On 10/02/2023 at 3:30 p.m., the facility submitted an accepted IJ removal plan and on 10/04/2023, submitted a revised plan which read as follows: "1. 9/27/23: Resident #103 reported an allegation of abuse on 8/10/2023 and FRI submitted regarding resident #85. 2. 9/27/23: FRI submitted for an allegation of abuse on 8/10/2023 involving resident #53 and #85. Physician, responsible party, and police notified, and case assigned to detective Alphin. 3. The identified CNA, [Name redacted], removed	F 607		

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from schedule on 8/10/2023 and no longer permitted in the center.
4. 9/28/2023: [Name redacted] license (CNA) reported to the board of nursing.
5. 9/28/2023: Facility personnel educated on the abuse policy to identify, protect, report, and investigate allegations of abuse prior to working.
6. 9/27/2023: New hires educated on abuse policy prior to working.
7. 9/27/2023: Regional Director of Human Resources reviewed all personnel files to verify Virginia State Police (VSP) background checks.
8. 10/2/2023: Employees with pending VSP background check clearances removed from the schedule.
9. 9/27/2023: Regional Human Resources educated Administrator and managers on screening employees and VSP background checks clearance.
10. 9/27/2023: The facility educated all personnel on protecting, reporting, investigation, screening employees, and adhering to a mandated reporting procedure.
11. 9/27/2023: The facility interviewed residents to determine if there was any other allegation of abuse.
12. 9/27/2023: skin checks completed on residents who could not be interviewed to determine any signs of abuse.
13. 9/27/2023: The facility completed a comprehensive audit of all FRIs and service concerns that occurred from January 2023 up to the present to ensure no other case of abuse existed.
14. 9/27/2023: The facility identified an allegation of abuse involving a receptionist, and resident #103.
15. Receptionist suspended pending an investigation. A FRI sent to the Office of

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F 607	Continued From page 37 Licensure and Certification on 9/26/2023. 16. The implementation deadline of this immediacy removal plan is October 2, 2023, by 3:20 PM." On 10/02/2023, the facility's administration submitted to the survey team credible evidence of the IJ immediacy removal plan. Included in the documents was documentation of "Direct Supervision," which indicated that employees without a criminal background check clearance would be permitted to work under the direct supervision of a staff member with a criminal background clearance. The survey team notified the facility's administration that this was not permissible, and that each employee had to have a criminal background check clearance to work beyond 30 days of employment. On 10/03/2023, the survey team attempted again to verify the facility staff had implemented their approved IJ immediacy removal plan. Staff interviews were conducted with facility staff from various departments to ensure they were aware of what abuse is, how to respond and protect residents in the event of abuse, and that they were mandated reporters. The survey team obtained a resident census listing and cross checked to ensure that residents who could be interviewed had been interviewed, and residents who could not be interviewed had a head-to-toe assessment. There was one resident identified that had not been interviewed or assessed for signs of abuse. The survey team reviewed the employee audits and identified that the contracted dietary, housekeeping, and laundry staff had not been	F 607		

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F 607	Continued From page 38 audited to ensure they had a criminal background check from the Virginia State Police that indicated they were free from any barrier crimes. On 10/03/23 at 4:40 p.m., the facility Administrator and corporate staff were made aware that the survey team had been unable to verify abatement. On 10/04/2023, the survey team returned to the facility for them to attempt to abate IJ. The facility staff provided the survey team with a head-to-toe assessment for the resident that had previously not been assessed for signs and symptoms of abuse. Additionally, the team reviewed the employee record audit and noted that the contracted staff were now listed. However, the audit indicated that Staff #24, who was a cook, was noted as having had a criminal background check. It had previously been noted as recently as 10/03/2023, Staff #24 did not have a criminal background check on-file at the facility and his status regarding barrier crimes and his criminal record remained unknown. In addition, 2 agency staff members were noted on the current working schedule for the day and there was not any evidence provided to indicate they had been screened for criminal records. On 10/04/2023 at approximately 10:00 a.m., the facility's Administrator was again made aware that they were unable to abate IJ. On 10/04/2023 at 10:40 a.m., the facility's Administrator returned with a revised audit which correctly reflected that Staff #24 did not have a criminal record on file. The audit verified that employees without a criminal background check had been removed from the schedule and were	F 607		

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F 607	Continued From page 39 not currently working. The facility's administration also provided a criminal background that was free from barrier crimes for the 2 agency staff working. The survey team confirmed IJ was abated on 10/04/2023 at 10:45 a.m. 4. For Resident #85, the facility staff failed to implement the abuse policy by reporting an allegation of sexual abuse. On or about 08/10/2023, an allegation that a CNA shaved the pubic hair of Resident #85, who is cognitively impaired and unable to be interviewed. The allegation was reported by the CNA who cares for her and the roommate of Resident #85. On 09/26/2023, an interview was conducted with Resident #103, who stated she knew that Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85. According to the audio recording, CNA E could be heard saying, "Why did you let that man shave you down there." Resident #85 has a Brief Interview of Mental Status (BIMS) score of 99, and stated she did not let anyone shave her to which you can hear the CNA reply, "You are mighty bald down there. You got less hair than me and I was waxed." On 09/27/2023 at 1:00 p.m., an interview was conducted with CNA E who admitted that she had knowledge of the incident and that she made the nurse and the former DON aware of the incident; however, she did not report it as abuse at that time. On 09/26/2023, an interview was conducted with the DON, who was asked if she reported the allegation of sexual abuse, and she stated that	F 607		

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F 607	Continued From page 40 she did not find it was abuse. She stated she heard about it from Resident #103, and she did not consider it abuse. The DON stated, "Coming from (Resident #103 name redacted) I don't believe it." When asked again if she followed the abuse policy, and reported to the appropriate parties, she stated she did not think it was abuse so she did not report it. A review of the Abuse Policy read: "All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		11/19/23

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F 609	Continued From page 41 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility failed to report allegations of abuse by a staff member involving 2 residents (Residents #53 and #85) in a survey sample of 48 residents. The findings included: 1. For Resident #53, the facility staff failed to complete a timely and accurate report of an allegation of physical and sexual abuse by CNA C to the state survey agency, adult protective services, and law enforcement. On 09/26/2023, during a clinical record review of Resident #53's clinical chart, the following were noted: a. A progress note dated 08/10/2023 at 5:06 p.m.	F 609	F609 Reporting of Alleged Violations 1. Resident #53 and resident #85 no longer reside in the facility. The identified agency CNA assigned to both residents since allegations on 8/10/2023 has not worked at the facility, FRIs were submitted for both residents #53 and #85 with investigation on 9/27/2023 with appropriate state agencies with accurate description of allegation and investigation include retained copies of documents to support findings of allegation. 2. Current residents in the facility have the potential to be affected. An audit of all service concerns and facility incident reports from 10/4/2023 were reviewed by the Regional Director of Clinical Services	

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F 609	Continued From page 42 read, "Patient sent to saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer." b. Another progress note dated 08/10/2023 at 5:15 p.m., stated, "Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges." On 09/27/2023, a review was conducted of the facility's documentation of the allegation and actions taken. There was a written statement that was taken from Resident #53 that read as follows: "Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist." There was evidence the state survey agency/Office of Licensure and Certification (OLC) and Adult Protective Services (APS) were faxed a report of the incident on 08/10/2023 at 7:10 p.m., almost 12 hours after facility management were made aware of the initial	F 609	(RDSC) and the Vice President of Operations (VPO) to identify any allegations of abuse/neglect with none noted. Residents were interviewed, with no concerns of any type of abuse. The facility also performed skin assessments on all residents that could not be interviewed, no areas identified. Resident # 103 reported allegation of abuse by an employee, the abuse policy followed, employee suspended pending investigation, resident protected, FRI submitted with appropriate state agencies and investigation conducted with supporting documentation completed. 3. The RDCS provided education to the Administrator and the DON on the abuse policy and procedures with timely reporting of FRI submitted with appropriate state agencies, accurate description of allegation, thorough investigation with retained documents to support findings. SDC or designee educated all facility staff on the abuse policies and procedures regarding protecting resident and/or residents, reporting to Administrator or DON, and submitting Facility Reported Incident (FRI) within 2 hours of allegation of abuse if other type of abuse and no serious bodily harm can report within 24 hours includes appropriate state agencies, and investigation process, importance and understanding of protecting the residents from any type of abuse. Any staff identified in an allegation of abuse will be suspended pending investigation immediately upon knowledge to protect the resident or other residents from	

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F 609	Continued From page 43 abuse allegation. Additionally, the report submitted grossly misrepresented the allegation(s) made. The report read, "It was reported to Speech therapist and floor nurse by [Resident #53's name redacted], BIMS [brief interview for mental status score] 14, that the aide who took care of him touched him inappropriately, cannot give date but states not today or yesterday but the same one that worked this morning. Aide immediately sent home upon knowledge pending investigation." During Surveyor F's investigation of this incident, payroll records revealed CNA C did not leave the facility on the day of the allegations until 1:17 p.m. On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility's Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, "On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 a.m. and gave me a service concern. She said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, she identified as [CNA C's name redacted] .... I asked him [Resident #53] if he wanted to be sent out, he said yes." The DON stated she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53.	F 609	potential abuse and/or emotional harm. 4. The RDCS or VPO will audit weekly x 4 weeks then monthly x 2 months any FRIs (facility incident reports) to verify the abuse policy was followed, resident protected if staff involved suspended pending investigation immediately, allegation of abuse reported within 2 hours, if other abuse and no serious bodily harm within 24 hours with appropriate state agencies, investigation compete with copies of documents retained to support findings. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 609	Continued From page 44 During the above interview, the DON was asked about the reporting of the incident. The DON was able to verbalize that reports regarding allegations of abuse are to be reported within 2 hours. When questioned about the timing of the report involving Resident #53, she did not respond as to why it was delayed. The DON was asked about the lack of details regarding Resident #53's allegations involving CNA C, in the report submitted. The details of being awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair and the details of the aggressive feeding were all omitted from the report. Again, the DON did not give an answer as to why those details were omitted. When asked if the allegations against CNA C were reported to the Board of Nursing, which is the agency that certified CNA C to practice as a nursing assistant, the DON said yes, but was unable to provide any credible evidence it was reported. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the speech language pathologist (SLP). The SLP confirmed Resident #53's report of abuse was reported to her on 08/10/2023, when she arrived to work at 7:50 a.m. She also stated she immediately reported the allegation to her departmental supervisor, the nursing unit manager, and then to the Director of Nursing. On 09/27/2023, Surveyors D and F attempted to interview Resident #53, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F	F 609		

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F 609	Continued From page 45 visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There was no change in his report. Resident #53 became very tearful, said he was so afraid, and that CNA C "laid me flat in the chair on my back and was trying to silence me and say I choked on food." Resident #53 said, "[Employee M's name redacted] took a picture." The resident stated following this incident he was afraid to sleep, kept looking around, and had to be prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, "Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time." A review was conducted of the facility's abuse policy titled, "Abuse/Neglect/Misappropriation/Crime/Reporting Requirements/Investigations." Excerpts from this policy read, "1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury. b. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime. c. Notify within 24 hours the Department of Health Professions (DHP) for	F 609		

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	495193		C 10/04/2023

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F 609	Continued From page 46 incidences involving nurse aides, RNs, LPNs, Physicians, or others licensed or certified by DHP." On 09/27/2023 and 09/28/2023, the facility's Administrator and corporate staff were made aware of the above findings. On 09/27/2023, the corporate staff notified the survey team they would be re-opening the investigation into the events involving Resident #53 and CNA C and had made an accurate report of the allegations to the required agencies/authorities. No further information was provided. 2. For Resident #85, the facility staff failed to ensure allegations of abuse are reported within 24 hours for allegations that do not result in serious bodily injury. On or about 08/10/2023, an allegation that a CNA shaved the pubic hair of Resident #85 who is cognitively impaired and unable to be interviewed. The allegation was reported by the CNA who cares for her and the roommate of the resident. On 09/26/2023, an interview was conducted with Resident #103 who stated she knew that Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85, "Why did you let that man shave you down there." Resident #85 has a Brief Interview of Mental Status (BIMS) score of 99 and stated that she did not let anyone shave her, to which you can hear	F 609		

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F 609	Continued From page 47	F 609		

the CNA reply "You are mighty bald down there. You got less hair than me and I was waxed." On 09/27/2023 at 1:00 p.m., an interview was conducted with CNA E who admitted that she had knowledge of the incident and that she made the nurse aware of the incident and the former DON was also made aware, however she did not report it as abuse at that time.

On 09/26/2023, an interview was conducted with the DON who was asked if she reported the allegation of sexual abuse and she stated that she did not find it was abuse. She stated she heard about it from Resident #103, and she did not consider it abuse. The DON stated, "Coming from (Resident #103 name redacted) I don't believe it." When asked again if she followed the Abuse Policy and reported the incident to the appropriate parties, she stated she did not think it was abuse, so she did not report it.

A review of the Abuse Policy read:
"All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury."

The incident was not reported nor investigated until 09/27/2023 2 days after the survey began. The incident was reported to the Office of Licensure and Certification, Adult Protective Services, the Dept of Health Professions, and the Police by the Regional Director of Clinical

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F 609	Continued From page 48 Services on 09/27/2023. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility failed to conduct investigations of allegations of abuse by a staff member involving 2 residents (Residents #53 and #85) in a survey sample of 48 residents. The findings included:	F 610	F610 Investigate/Prevent/Correct Alleged Violation 1. Resident #53 and resident #85 no longer reside at the facility. The identified agency CNA assigned to both residents since allegations on 8/10/2023 has not worked at the facility, ongoing police investigation and reported	11/19/23

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F 610	Continued From page 49 1. For Resident #53, who reported an allegation of physical and sexual abuse by CNA C, the facility staff failed to conduct an investigation and take measures to prevent further abuse while an investigation was conducted. On 08/10/2023, Resident #53 reported an allegation of abuse to facility staff. On 09/26/2023, during a clinical record review of Resident #53's clinical chart the following was noted: a. A progress note dated 08/10/2023 at 5:06 p.m., read, "Patient sent to saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer." b. Another progress note dated 08/10/2023 at 5:15 p.m., stated, "Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges." On 09/27/2023, a review was conducted of the facility's documentation of the allegation and actions taken. There was a written statement that was taken from Resident #53 that read as follows: "Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back	F 610	to the Board of Nursing, FRIs were submitted for both residents #53 and #85 with investigation on 9/27/2023. 2. Current residents in the facility have the potential to be affected. Residents were interviewed, with no concerns of any type of abuse. The facility also performed skin assessments on all residents that could not be interviewed., no areas form of abuse were identified. Resident # 103 reported allegation of abuse by an employee, the abuse policy followed, employee suspended pending investigation, resident protected, FRI submitted with appropriate state agencies and investigation with supporting documentation completed. 3. The Regional Director of Clinical Services (RDCS) educated the Administrator, DON and all Department Managers on the abuse policy, FRI submitted with accurate description of allegation and thorough investigation with documentation to support findings. SDC or designee educated all facility staff on the abuse policies and procedures regarding protecting resident and/or residents, reporting to Administrator or DON, and submitting Facility Reported Incident (FRI) within 2 hours of allegation of abuse if other type of abuse and no serious bodily harm report within 24 hours includes appropriate state agencies, and investigation process, importance and understanding of protecting the residents from any type of abuse. Any staff identified in an allegation of abuse will be suspended pending investigation immediately upon knowledge to protect	

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F 610	Continued From page 50 and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist." There was also a written statement from Employee M, the Speech Language Pathologist (SLP). Lastly, there was evidence the state survey agency, Office of Licensure and Certification (OLC), and Adult Protective Services (APS) were faxed a report of the incident on 08/10/2023 at 7:10 p.m. There was no evidence an investigation into the allegations was conducted. During Surveyor F's investigation of this incident, payroll records revealed CNA C did not leave the facility on the day of the allegations until 1:17 p.m., despite the initial report being made at approximately 7:50 a.m. Following that initial incident of physical and sexual abuse, CNA C then continued to provide care for Resident #53 and at 9:30 a.m., was seen aggressively feeding the resident, to the point the SLP had to intervene for the resident's safety and welfare. On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility's Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, "On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 AM and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did	F 610	the resident or other residents from potential abuse and/or emotional harm. The Administrator, Staff Development Coordinator and all Department Heads educated all staff on the policy and procedure for abuse policy and mandating reporting and the investigation process with supporting documentation. All staff understand they are mandated reporters and must report witnessed or allegation of abuse with accurate description and knowledge of allegation for staff statement. 4. The RDCS or designee will audit weekly x 4 weeks then monthly x2 months on any FRI submitted to verify accurate description of allegation, resident protected, employee time of suspension, and thorough investigation with documentation to support findings. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 5. Date of compliance: 11/19/2023	

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F 610	Continued From page 51 foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day," which she identified as [CNA C's name redacted]. "I asked him [Resident #53] if he wanted to be sent out, he said yes." The DON stated she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. During the above interview, the DON was asked to explain what steps were taken to investigate the allegation and if she had any additional documentation regarding the investigation. The DON stated she had interviewed other residents and reviewed the hospital records of Resident #53, and because there was no forensic evidence, she unsubstantiated the allegation. The DON was asked to provide evidence of the residents' interviews she conducted, and she said she had nothing to provide. When asked if staff, including but not limited to CNA C, were interviewed, the DON indicated no. The facility had no evidence of any investigation being conducted. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the speech language pathologist (SLP). The SLP confirmed Resident #53's report of abuse reported to her on 08/10/2023, when she arrived to work at 7:50 a.m. She also stated she immediately reported the allegation to her departmental supervisor, the nursing unit manager, and then to the Director of Nursing. On 09/27/2023, Surveyors D and F	F 610		

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F 610	Continued From page 52 attempted to interview Resident #53, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There was no change in his report. Resident #53 became very tearful, said he was so afraid, and that CNA C "laid me flat in the chair on my back and was trying to silence me and say I choked on food." Resident #53 said, "[Employee M's name redacted] took a picture." The resident also stated that following this incident, he was afraid to sleep, kept looking around, and had to be prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, "Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time." A review was conducted of the facility's abuse policy titled, "Abuse/Neglect/Misappropriation/Crime/Reporting Requirements/Investigations." Excerpts from this policy read, "2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations." On 09/27/2023 and 09/28/2023, the facility Administrator and corporate staff were made aware of the above findings. The corporate staff	F 610		

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F 610	Continued From page 53 notified the survey team they would be re-opening the investigation into the events involving Resident #53 and CNA C. No further information was provided. 2. For Resident #85, the facility staff failed to thoroughly investigate an allegation of sexual abuse at the time it occurred. On or about 08/10/2023, an allegation that a CNA shaved the pubic hair of Resident #85 who is cognitively impaired and unable to be interviewed. The allegation was reported by the CNA who cares for her and the roommate of the resident. On 09/26/2023, an interview was conducted with Resident #103 who stated she knew that Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85. According to the audio recording, CNA E stated, "Why did you let that man shave you down there?" Resident #85 has a Brief Interview of Mental Status (BIMS) score of 99, and stated that she did not let anyone shave her to which you can hear the CNA reply, "You are mighty bald down there. You got less hair than me and I was waxed." On 09/27/2023 at 1:00 p.m., an interview was conducted with CNA E who admitted she had knowledge of the incident and that she made the nurse and the former DON aware of the incident; however, she did not report it as abuse at that time. On 09/26/2023, an interview was conducted with the DON who was asked if she reported the	F 610		

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F 610	Continued From page 54 allegation of sexual abuse and she stated that she did not find it was abuse. She stated she heard about it from Resident #103, and she did not consider it abuse. The DON stated, "Coming from (Resident #103 name redacted) I don't believe it." When asked again if she followed the abuse policy and reported it to the appropriate parties, she stated she did not think it was abuse, so she did not report it. A review of the Abuse Policy read: "All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." The incident was not reported nor investigated until 09/27/2023, 2 days after the survey began. The incident was reported to the Office of Licensure and Certification, Adult Protective Services, the Department of Health Professions, and the Police by the Regional Director of Clinical Services on 09/27/2023. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.	F 610		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility	F 637		11/19/23

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F 637	Continued From page 55 determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a comprehensive assessment after significant change in a timely manner for one resident (Resident #19) in a survey sample of 48 residents. For Resident #19, the facility staff failed to perform a significant change in status assessment after 2 areas of decline in pressure ulcer formation after hospitalization, and significant weight loss prior to and after hospitalization within 14 days of knowing about the 2 declines. The findings included: For Resident #19, the facility staff did not intervene during the significant weight loss of a resident with known dysphagia following a stroke, insulin dependent Diabetes Mellitus, and 3 wounds. Resident #19 was admitted to the facility on 12/26/2022, and most recently readmitted after	F 637	F637 Comprehensive Assessment After Significant Chg 1. Resident #19 still resides in the facility. Resident #19 had a nutritional assessment by registered dietitian with diet texture change with supplements per physician orders and hydration risk updated on care plan 11/9/2023. 2. Current residents in the facility have the potential to be affected. An audit of current residents by the registered dietitian (RD) or designee conducted to identify any other resident with significant weight loss. An audit of by DON or designee on current residents with physician orders for hydration replacement is reflected on resident□s care plan and an audit to identify residents that require to be fed or assistance, cuing have care plan reviewed and updated to indicate level of assistance needed. Any findings the RD will complete a nutritional assessment with supplemental orders if applicable by physician and hydration	

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F 637	Continued From page 56 hospitalization on 09/19/2023 with diagnoses including; encephalopathy, urinary tract infection, oral cadidiasis, and COVID-19. Resident #19 had a medical history including, stroke, diabetes, and acute gastrointestinal bleeding with resulting acute post hemorrhagic anemia and weakness from the 12/26/2022 admission. Resident #19's most recent quarterly Minimum Data Set (MDS) assessment was dated with an assessment reference date of 06/21/2023, and coded the resident as moderately cognitively impaired, required extensive assistance with feeding, coded no wounds nor skin problems, at risk for malnutrition, weight 148.0 lbs (pounds), and no swallowing issues. The assessment was in error as the resident had 2 ongoing long standing foot wounds from an original admission known for years. It is notable to add that no significant change to the MDS assessment was completed from Resident #19's readmission from the hospital on 09/19/2023 through the time of survey ending 10/04/2023 (15 days after readmission). Resident #19 had a known significant weight loss before hospitalization, and a new pressure sore on Resident #19's right buttock found on the day of readmission at unstageable due to slough in the wound bed. These issues would require further nutritional support for wound healing and significant weight loss. According to the regulation, a significant change assessment should be conducted within 14 days of a known decline in 2 or more areas such as unplanned weight loss and a new unstageable pressure wound. On 01/02/2023, the Registered Dietician (RD)	F 637	replacement is care planned. 3. The SDC or designee will educate the licensed nurses, MDS staff, Director of Activities and Activity, RD, speech therapist and nursing management (DON, unit mangers, supervisors) on the process for identification of significant change meets criteria to submit a MDS assessment for significant change in conditions. RD will complete nutritional assessment with identified residents at risk for weight loss or with significant weight loss with supplements as applicable per physician order and care plan updated. MDS or nursing management will initiate, revise/update care plan for hydration replacement. CNAs, licensed nurses, or speech therapist will provide feeding assistance for identified residents that required to be fed, cueing or need assistance. Report to nurse of resident does not eat with documentation. Activities opportunities for food intake of food and hydration for identified residents at risk or actual weight loss. 4. Director of MDS or designee will audit weekly x 4 weeks then monthly x 4 to determine if resident meets the criteria for a significant change in condition with MDS assessment completed if meets criteria. DON or designee will audit weekly x 4 weeks then monthly x 2 months to verify resident with significant weight loss have RD nutrition assessment with supplements as applicable per physician order and care plan updated, conduct observation audits on 10 residents that require assistance with eating to verify are	

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F 637	Continued From page 57 evaluated Resident #19, and documented "Nutrition Assessment (A) Diagnoses...regular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none, ...pressure wound, medications named...Nutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated, "Nutrition Assessment (A) quarterly ARD 6-21-23...Diagnoses...regular diet regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications named...continue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. weight 148.3 lbs (pounds)." On 09/07/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began 09/25/2023 and ended on 10/04/2023. Resident #19's weight document was reviewed and revealed the following: 1. 07/03/2023 - 145.0 pounds 2. 08/07/2023 - 140.2 pounds (5 pound weight loss in one month begins)	F 637	being fed and audit residents receiving hydration have care plan initiated or updated. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 637	Continued From page 58 3. 09/06/2023 - 131.6 pounds (now a 14 pound (10 %) weight loss in 2 months) 4. 09/11/2023 - 129.0 pounds (now a 16 pound weight loss 9 weeks) Resident #19 went out to the hospital on 09/16/2023, and returned on 09/19/2023. 5. 09/19/2023 - 135.0 (a 6 pound weight gain during hospitalization) 6. 09/25/2023 - 126.0 pounds (a 9 pound weight loss begins again) 7. 09/27/2023 - 119.4 pounds (now almost 20% weight loss in less than 4 months) and weight loss continues. Physician and RD orders were reviewed, and revealed that from 01/03/2023, multivitamin was ordered and discontinued on 06/30/2023, the regular diet was discontinued on 06/30/2023, and the Ensure Compact supplement was discontinued on 06/01/2023. The Med Plus 2.0 supplement was started on 06/01/2023, and discontinued on 06/30/2023. There were no orders for supplements after the 06/30/2023 discontinuance until 09/19/2023, after a significant weight loss had occurred and been ongoing for months. The multivitamin, and Med Plus 2.0 were restarted on 09/19/2023; however, the Med Plus 2.0 supplement was discontinued nine days later on 09/28/2023 by a physician's order. Weekly weights were obtained beginning 09/06/2023, indicating knowledge of the significant weight loss (10 days) before hospitalization on 09/16/2023 for Resident #19; however, no interventions were added for the weight loss. The medication administration record (MAR) documented that the Med plus 2.0 was given	F 637		

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F 637	Continued From page 59 daily after 09/28/2023, even after being discontinued, and on 09/28/2023, the diet was changed to mechanically altered which dietary staff indicated meant chopped. Resident #19 did not receive supplements from 06/30/2023 through 09/19/2023 during a significant weight loss, and the RD did not evaluate nor intervene during a significant weight loss. Resident #19's nutrition care plan, completed and initiated on 01/02/2023, was canceled on 09/18/2023 by the RD. No new nutrition care plan nor any other care plan had been completed at the time of survey on 09/25/2023, nor through 09/27/2023 (9 days after readmission) when documents were obtained. The new readmission care plan was "in development" according to staff nurses when asked to review the care plan in the electronic clinical record. Resident #19 did not have a dehydration care plan even though the resident had experienced dehydration in the facility and received Clysis fluid resuscitation instilled subcutaneously on several occasions. Resident #19 did not receive diuretic medications which assists with removing fluid from the body. Activities of Daily Living records (ADLs) were reviewed and revealed Resident #19 needed to be assisted and received extensive assistance. The resident consumed varying amounts of meals from 0% to 75%. Family interviews to include the resident's daughter, and granddaughter, who stated she was a Licensed Practical Nurse (LPN), revealed	F 637		

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F 637	Continued From page 60 that Resident #19 had to be fed and will, at times, accept things in her hands to eat, such as sandwiches. However, she must be cued to eat them. The family was very involved with the resident's care and were in the facility almost daily. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since Resident #19 was readmitted on 09/19/2023, and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being assisted by one staff member to set-up, and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. The resident was not eating and Certified Nursing Assistant (CNA) D, who was sitting with the residents, stated she would be feeding Resident #19. Observations were continued and only one teaspoonful of potatoes was placed up to the mouth of Resident #19, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to the resident.	F 637		

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F 637	Continued From page 61 At 1:15 p.m., CNA D was interviewed and asked why she had not fed Resident #19. CNA D stated, "She (Resident#19) was very sleepy, so I told the nurse (LPN D) and didn't offer her any more food." LPN (Licensed Practical Nurse) D was interviewed and stated, "the speech therapist was changing the resident's diet" and the resident "would receive another tray, but the resident has thrush so she probably won't eat anyway." The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated "she didn't tell me that." Resident #19 was observed for the rest of the shift, and never received another tray. It is notable to mention that the resident's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. On 09/29/2023 at the end of day debriefing, the Administrator and Regional Director of Operations were notified of the findings for Resident #19. On 10/04/2023 at approximately 2:00 p.m., the Administrator, Corporate Nurse Consultant, and Regional Director of Operations were again notified of the findings, and they stated they had nothing further to provide.	F 637		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		11/19/23

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F 655	Continued From page 62 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, and clinical	F 655	F655 Baseline Care Plan .	

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F 655	Continued From page 63 record review, the facility staff failed to complete a 48-hour baseline care plan for one resident (Resident #19) in a survey sample of 48 residents. For Resident #19, the facility staff failed to develop and operationalize a 48-hour base line care plan after readmission and discontinuance of the resident's former care plan, which was canceled. The findings included: For Resident #19, the facility staff did not intervene during the significant weight loss of a resident with known dysphagia following a stroke, insulin dependent Diabetes Mellitus, and 3 wounds. Resident #19 was admitted to the facility on 12/26/2022, and most recently readmitted after hospitalization on 09/19/2023 with diagnoses including, encephalopathy, urinary tract infection, oral cadidiasis, and COVID-19. The resident had a medical history including, stroke, diabetes, and acute gastrointestinal bleeding with resulting acute post hemorrhagic anemia and weakness from the 12/26/2022 admission. Resident #19's most recent quarterly Minimum Data Set (MDS) assessment was dated with an assessment reference date of 06/21/023, and coded the resident as moderately cognitively impaired, required extensive assistance with feeding, coded no wounds nor skin problems, at risk for malnutrition, weight 148.0 lbs (pounds), and no swallowing issues. The assessment was in error as Resident #19 had 2 ongoing long standing foot wounds from an original admission	F 655	1. Resident #19 still resides in the facility. The timeframe has passed to correct for baseline care plan. A copy of the care plan reflects the resident current plan of care was reviewed with RP and copy given. Resident #19 is cognitively impaired. 2. Current residents in the facility have the potential to be affected. An audit of current residents admitted from 10/4/2023 to verify resident if cognitively appropriate and RP received a copy of baseline care plan. Any findings were corrected with copy reviewed / given. 3. The SDC or designee will educate all discharge planners and licensed nurses on the process of completion of baseline care plans within 48 hours to reflects current plan of care needs with copy reviewed and given to resident if cognitively appropriate and to RP with documentation, 4. The discharge planner director or designee will audit weekly x 4 weeks then monthly x 2 to verify a copy of the baseline care plan was given to the resident if cognitively appropriate and to the RP with documentation within 48 hours. Any findings will be corrected. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained, the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 655	Continued From page 64 known for years. It is notable to add that no significant change MDS assessment was completed from Resident #19's readmission from the hospital on 09/19/2023 through the time of survey ending on 10/04/2023 (15 days after readmission). Resident #19 had a known significant weight loss before hospitalization, and a new pressure sore on the resident's right buttock was found on the day of readmission at unstageable due to slough in the wound bed. These issues would require further nutritional support for wound healing and significant weight loss. According to the regulations, a significant change assessment should be conducted within 14 days of a known decline in 2 or more areas such as unplanned weight loss and a new unstageable pressure wound. On 01/02/2023, the Registered Dietician (RD) evaluated Resident #19 and documented "Nutrition Assessment (A) Diagnoses...regular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none, ...pressure wound, medications named...Nutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated; "Nutrition Assessment (A) quarterly ARD 6-21-23 .....Diagnoses...regular diet regular texture, thin	F 655		

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F 655	Continued From page 65 liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications named...., continue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. Weight 148.3 lbs (pounds)." On 09/27/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began 09/25/2023 and ended 10/04/2023. Resident #19's weight document was reviewed and revealed the following: 1. 07/03/2023 - 145.0 pounds 2. 08/07/2023 - 140.2 pounds (5 pound weight loss in one month begins) 3. 09/06/2023 - 131.6 pounds (now a 14 pound (10 %) weight loss in 2 months) 4. 09/11/2023 - 129.0 pounds (now a 16 pound weight loss 9 weeks) Resident #19 went out to the hospital on 09/16/2023 and returned on 09/19/2023. 5. 09/19/2023 - 135.0 (a 6 pound weight gain during hospitalization) 6. 09/25/2023 - 126.0 pounds (a 9 pound weight loss begins again) 7. 09/27/2023 - 119.4 pounds (now almost 20% weight loss in less than 4 months) and weight loss continues. Physician and RD orders were reviewed and revealed that from 01/03/2023, multivitamin was ordered and discontinued on 06/30/2023, the regular diet was discontinued on 06/30/2023, and	F 655		

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F 655	Continued From page 66	F 655		

the Ensure Compact supplement was discontinued on 06/01/2023. The Med Plus 2.0 supplement was started on 06/01/2023 and discontinued on 06/30/2023.

There were no orders for supplements after the 06/30/2023 discontinuance until 09/19/2023 after a significant weight loss had occurred and been ongoing for months. The multivitamin and Med Plus 2.0 were restarted on 09/19/2023; however, the Med Plus 2.0 supplement was discontinued nine days later on 09/28/2023 by a physician's order. Weekly weights were obtained beginning 09/06/2023, indicating knowledge of the significant weight loss (10 days) before hospitalization on 09/16/2023 for Resident #19; however, no interventions were added for the weight loss.

The medication administration record (MAR) documented that the Med plus 2.0 was given daily after 09/28/2023, even after being discontinued, and on 09/28/2023, the diet was changed to mechanically altered which dietary staff indicated meant chopped.

Resident #19 did not receive supplements from 06/30/2023 through 09/19/2023 during a significant weight loss, and the RD did not evaluate nor intervene during a significant weight loss.

Resident #19's nutrition care plan, completed and initiated on 01/02/2023, was canceled on 09/18/2023 by the RD. No new nutrition care plan nor any other care plan had been completed at the time of survey on 09/25/2023 nor through 09/27/2023 (9 days after readmission) when documents were obtained. The new readmission

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F 655	Continued From page 67 care plan was "in development" according to staff nurses when asked to review the care plan in the electronic clinical record. Resident #19 did not have a dehydration care plan even though the resident had experienced dehydration in the facility and received Clysis fluid resuscitation instilled subcutaneously on several occasions. Resident #19 did not receive diuretic medications which remove fluid from the body. Activities of Daily Living records (ADLs) were reviewed and revealed that Resident #19 needed to be assisted and received extensive assistance. The resident consumed varying amounts of meals from 0% to 75%. Family interviews to include the resident's daughter and granddaughter, who stated she was an Licensed Practical Nurse (LPN), revealed that the resident had to be fed and will at times accept things in her hands to eat, such as sandwiches; however, she must be cued to eat them. The family was very involved with the resident's care and were there in the facility almost daily. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since Resident #19 was readmitted on 09/19/2023, and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being	F 655		

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F 655	Continued From page 68	F 655		

assisted by one staff member to set up, and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. Resident #19 was not eating and CNA (Certified Nursing Assistant) D, who was sitting with the residents, stated she would be feeding Resident #19.

Observations were continued and only one teaspoonful of potatoes was placed up to the mouth of Resident #19, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to Resident #19.

At 1:15 p.m., CNA D was interviewed and asked why she had not fed Resident #19. CNA D stated, "She (Resident#19) was very sleepy so I told the nurse (LPN D) and didn't offer her any more food. LPN (Licensed Practical Nurse) D was interviewed and stated, "the speech therapist was changing the resident's diet" and Resident #19 "would receive another tray, but the resident has thrush so she probably won't eat anyway." The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated, "she didn't tell me that." The resident was observed for the rest of the shift, and never received another tray. It is notable to mention that Resident #19's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident.

On 09/29/2023 at the end of day debriefing, the

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F 655	Continued From page 69 Administrator and Regional Director of Operations were notified of findings for Resident #19. On 10/04/2023 at approximately 2:00 p.m., the Administrator, Regional RN consultant, and Corporate Director of Operations were made aware of findings, and they stated they had nothing further to provide.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		11/19/23

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F 657	Continued From page 70 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to review and revise care plans for 2 residents (Residents #21 and #53), in a survey sample of 48 residents. The findings included: 1. For Resident #21 the facility staff failed to review and revise the care plan to include interventions after a fall with fractured femur and surgical repair. On 09/25/2023 at approximately 2:30 p.m., Resident #21 was observed in her wheelchair in her room looking out of the window. She had bare feet. She stated she had a fall a while ago and now is in a wheelchair. She was not sure when the fall occurred or if it was at home or in the facility. A review of the clinical record revealed that Resident #21 had fallen in the facility on 04/03/2023 and was sent to the hospital on 04/05/2023 with a diagnosis of fractured right hip. Upon return to the facility, the care plan was not updated to include a foley, surgical incision, PT/OT, limitations, nor any new fall interventions since returning from the hospital on 04/10/2023. The care plan regarding falls read as follows: FOCUS: The resident has had an actual fall with the potential for further falls IDT expects fluctuations with declines as dementia progresses. Date Initiated: 03/01/2021 Created	F 657	F657 Care Plan Time and Revision 1. Resident #21 resides in the facility. Resident #21 care plan was updated to reflect current plan of care needs. Resident #53 no longer resides in the facility. 2. Current residents in the facility have the potential to be affected. An audit was conducted by MDS staff or designee on current residents□ care plans admitted from 10/4/2023 and resident who had a change in condition or fall since 10/4/2023 to verify care plans initiated, revised/updated to reflect current resident care needs with intervention for falls. Any findings were corrected. 3. The DON or designee will educate the MDS staff and the unit managers on the process for care plans initiated, revised, and updated for change in condition, new admit and readmits reflect the resident□s current plan of care needs and resident who fall required care plan reviewed and updated with interventions to prevent further falls and/or injuries. The SDC or designee will educate the current licensed nurses on the process for resident□s care plans to reflect current plan of care needs for new admits, readmits, and change in condition and resident who fall required care plan reviewed and updated with interventions to prevent further falls and/or injuries. 4. The MDS staff will audit weekly x 4 weeks and monthly x 2 months to verify	

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F 657	Continued From page 71 on: 03/01/2021. GOAL: The resident will resume usual activities without further incident through the review date. Date Initiated: 03/01/2021 Created on: 03/01/2021 Revision on: 04/24/2023 Target Date: 07/15/2023. INTERVENTIONS: Assist with repositioning in bed Date Initiated: 05/02/2021 Created on: 05/02/2021. Education regarding call for assistance Date Initiated: 04/03/2023 Created on: 04/03/2023. Floor mats Date Initiated: 03/01/2021 Created on: 03/01/2021 Revision on: 04/06/2023. Provide activities that promote exercise and strength building where possible. Date Initiated: 04/03/2023 Created on: 04/03/2023. Reeducate resident to wear no skid socks or shoes when ambulating Date Initiated: 04/04/2023 Created on: 04/04/2023. Re-direct resident and provide diversional activities when noted wandering aimlessly. Date Initiated: 07/28/2021 Created on: 08/16/2021. On 09/27/2023, an interview was conducted with LPN C who was asked when care plans should be updated, and she stated they should be updated as the care needs of the resident change. When asked who updates the care plans, she stated that usually the MDS coordinator or the DON updates the care plans. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #53, the facility staff failed to	F 657	care plan reflect current resident plan of care needs for new admits, readmits, and change in condition and if resident has a fall care plan verified updated with intervention. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists and is sustained, the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 657	Continued From page 72	F 657		

update the care plan to include Clysis orders for hydration.

On 09/26/2023 during clinical record review, it was noted that Resident #53 was started on Clysis due to "AKI" (Acute Kidney Injury).

"Sodium Chloride Solution 0.9 % Use 100 ml/hr. intravenously X 24 hours for AKI for 2 Days FOR 1.5L, use Clysis 60ml/hr. if iv line not obtained 9/22/2023 6:00 PM."

"9/23/2023 12:06 AM Orders - Administration Note Text: Clysis placed to right posterior/lateral thigh d/t residents' size/amount of fatty tissue. Inserted subcutaneously, covered with transparent dressing noted clean, dry, and intact. 0.9% Sodium Chloride infusing via doppler flow at 60ml; resident tolerated well. As of 0011; resident resting peacefully with Clysis intact without any issues noted. Resident to receive a total of 1.5L for AKI. Staff to continue to monitor."

"9/23/2023 8:50 PM Health Status Note Text: Resident fine, tolerating Clysis (sodium chloride) well. Ate 90% of dinner with ensure. No complaint of pain and no s/s of distress noted. Will continue to monitor throughout the rest of the shift."

A review of the clinical record revealed the care plan had not been updated since the initial care plan on admission. There was no update to reflect the start of IV fluids or Clysis if the IV line could not be started.

"FOCUS: The resident has dehydration or potential fluid deficit r/t Infection Date Initiated: 08/10/2023 Created on: 08/10/2023.
GOAL: The resident will be free of symptoms of

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F 657	Continued From page 73 dehydration and maintain moist mucous membranes, good skin turgor. Date Initiated: 08/10/2023 Created on: 08/10/2023. INTERVENTIONS: Encourage the resident to drink fluids of choice. See md order for extra fluids Date Initiated: 08/10/2023. Created on: 08/10/2023. Ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements. Date Initiated: 08/10/2023. Lab work as ordered Date Initiated: 08/10/2023 Created on: 08/10/2023. Monitor/document/report PRN any s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Date Initiated: 08/10/2023 Created on: 08/10/2023." On 09/27/2023, an interview was conducted with LPN B who stated that the MDS Coordinator or the DON are the ones who update the care plans. When asked if a change in condition or treatment should warrant an update on the care plan, she stated that it should. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		11/19/23

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F 658	Continued From page 74 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care and services in accordance with professional standards for 1 resident, Resident #362, in a survey sample of 48 residents. The findings included: For Resident #362, facility staff failed to administer medications as ordered by the physician on 07/17/2023 and 07/18/2023. On 09/28/2023, Resident #362's clinical record was reviewed and revealed physician orders and medication administration times as follows: *Aspirin EC-low dose tablet delayed release, 81mg, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Ferrous Sulfate tablet 325 (65 Fe)mg, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Finasteride tablet 5mg, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Gabapentin Oral Capsule 300mg, give 1 capsule by mouth at bedtime--ordered on 7/17/23, documented as given on 7/18/23	F 658	F658 Services Provided Meet Professional Standards 1. Resident #362 no longer resides in the facility. 2. Current residents in the facility have the potential to be affected. An audit by the DON or designee on the current resident□s admitted since 10/4/2023 to verify residents□ medication transcribed with scheduled medication date and time, available, and administered per physician order. Any findings will be corrected. 3. The SDC or designee will educate all licensed nurses on the processes for transcribing medication orders with scheduled medication date and time, obtaining medication from pharmacy and process for unavailable medications and medications administered per physician order. 4. The Unit Manager or designee will audit weekly x 4 weeks then monthly x 2 months to ensure new admits medications were transcribed, scheduled with accurate date and time, available and administered per physician orders and unavailable medication process was followed. Any findings will be corrected. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist	

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F 658	Continued From page 75 *Multiple Vitamin Tablet, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Nifedipine ER Oral Tablet Extended Release 24 Hour 90mg, give 120mg by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Carvedilol Oral Tablet 6.25mg, give 6.25mg by mouth two times a day--ordered on 7/17/23, documented as given on 7/18/23 *Eliquis Oral Tablet 2.5mg, give 2.5mg by mouth two times a day--ordered on 7/17/23, documented as given on 7/18/23 On 10/02/2023 at approximately 2:00 p.m., an interview was conducted with the Clinical Nurse Consultant (CNC) who confirmed the findings and stated that medications are expected to be given as ordered by the physician. She verified Resident #362 was actually admitted on 07/17/2023 and stated, "It appears that most of his [Resident #362's] med orders weren't entered into the system on the day of his admission as they should have been, it is my expectation that upon any resident's arrival to our facility, the admitting nurse will enter all admitting orders which includes all medications, if there is a question about medications then the nurse should contact the doctor for clarification and document it in a note, this nurse failed to follow our admissions process." The admitting nurse was unavailable to interview. The CNC stated the facility's professional nursing standards reference was "Lippincott." A facility policy on medication administration was requested and received.	F 658	and sustained, the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 658	Continued From page 76 Review of the facility policy entitled, "General Guidelines for Medication Administration," revised 08-2020, heading "Policy" read, "Medications are administered as prescribed in accordance with good nursing principles and practices..." According to Lippincott "Nursing Procedures," Seventh Edition, 2016, section entitled, "Oral Drug Administration," steps in the implementation of medication administration included but were not limited to: "Verify the medication is being administered at the proper time...to reduce the risk of medication errors." On 10/02/2023 at the end of day meeting, the facility Administrator was updated on the findings. No further information was provided.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide Activities of Daily Living (ADL) assistance to residents residing on 1 of 2 nursing units. The findings included: 1. For Resident #19, who was dependent upon facility staff for eating, the facility staff failed to provide assistance with the meal to ensure the	F 677	F677 ADL Care for Dependent Residents 1. Resident #19 still resides in the facility. The timeframe has passed to correct. Resident #19 is being assisted with feeding with documentation. 2. Current residents in the facility have the potential to be affected. An audit by the DON or designee to identify dependent residents that require need to be fed, assisted or cued and have care	11/19/23

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F 677	Continued From page 77 resident was fed a meal. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being assisted by one staff member to set up, and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. The resident was not eating and CNA (Certified Nursing Assistant) D who was sitting with the residents stated she would be feeding Resident #19. Observations were continued and only one teaspoonful of potatoes was placed up to the mouth of Resident #19, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to the resident. At 1:15 p.m., CNA D was interviewed and asked why she had not fed the resident. CNA D stated "She (Resident#19) was very sleepy so I told the nurse (LPN D) and didn't offer her any more food. LPN (Licensed Practical Nurse) D was interviewed and stated that "the speech therapist was changing the resident's diet" and that the resident "would receive another tray, but the resident has thrush so she probably won't eat anyway." The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated "she didn't tell me that."	F 677	plan reviewed and updated to indicate level of assistance needed. 3. The SDC will educate the CNAs, licensed nurses, or speech therapist on the process for identifying dependent residents that require feeding assistance, will be fed, assisted or cued, the resident will be appropriately fed, do not rush and allow time for resident to clear food from mouth prior to giving more food. Report to nurse of resident does not eat with documentation. ADL and incontinent care provide timely, answering of call bells timely to meet resident□s needs. Care plans /Kardex will identify level of assistance. Therapy referral for declines in ability to feed self or changes in swallowing ability or not eating, report to nurse refusal of care and document. Resident if cognitively appropriate and RP receive copies of baseline care plans and are invited to attend care plan meetings by the discharge planner or designee. 4. DON or designee will conduct observation audits weekly x 4 weeks then monthly x 2 months on 10 residents that require assistance with eating, incontinent care, call bell response time to verify are being fed, incontinent care provided, and call bells are answered timely. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 5. Date of compliance: 11/19/2023	

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F 677	Continued From page 78 Resident #19 was observed for the rest of the shift, and never received another tray. It is notable to mention that the resident's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. Activities of Daily Living (ADL) records were reviewed and revealed that Resident #19 needed to be assisted and received extensive assistance. The resident consumed varying amounts of meals from 0% to 75%. Family interviews to include the resident's daughter, and granddaughter, who stated she was an Licensed Practical Nurse (LPN), revealed that the resident had to be fed and will at times accept things in her hands to eat, such as sandwiches; however, she must be cued to eat them. The family was very involved with the resident's care and were there in the facility almost every day. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since the resident was readmitted on 09/19/2023, and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. 2. Resident Council expressed ongoing concerns over the lack of incontinence care, with no resolution. On 09/26/2023 at 1:00 p.m., a group meeting was held with 6 residents who were members of the Resident Council. During this meeting with the Surveyor, residents verbalized ongoing concerns over the lack of call bell response time and ADL assistance for residents who are incontinent.	F 677		

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F 677	Continued From page 79 The residents stated, residents who cannot ambulate and have dementia are left in the "day room area" on the South Hall all day without being changed. Six of the six residents in attendance at the Resident Council meeting stated, that the room is supposed to be used for activities; however, the staff park residents in there and they cannot do activities. They stated the room always smells of urine and feces because they do not change the residents they park in there. A review of the Resident Council minutes for the past 6 months revealed that residents are complaining about call bell answer times and improper incontinent care repeatedly. Review of the grievances revealed the same, ongoing concerns about incontinence care and assistance with ADLs. On 10/03/2023 during an end of day meeting, the facility Administrator was made aware of the above findings. No further information was provided.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		11/19/23

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F 689	Continued From page 80 This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation, and clinical record review, the facility staff failed to ensure the resident environment remains free of accident hazards for 1 of 2 units. The findings included: For the residents using the showers on the South Hall the facility, staff failed to ensure the shower room tiles were in good repair. On 09/26/2023 at 2:00 p.m. during the Resident Council meeting, it was brought up that the shower rooms were dirty, and Resident #42 added that the shower room has bugs and is dirty. Residents #68 and #18 added that in the shower cubical, the tiles are loose and coming up out of floor. When asked how long this was going on 6 of 6 residents in attendance agreed that it has been a few months (more than 2). When asked were staff aware of the issue, Resident #42 stated and the group agreed "The staff have to be aware they are giving showers to residents in that room." On 09/26/2023 at 4:00 p.m., this surveyor accompanied the Maintenance Director to the shower rooms to observe the condition of the shower room. Upon entering the shower room, the first stall had black and white tiles that were pulled up and several were missing. An interview was conducted with the maintenance director who was asked if that presents a safety issue. The maintenance director stated that it does present a potential safety issue as tiles may be sharp and a resident could possibly cut their feet	F 689	F689 Free of Accident Hazards/Supervision/Devices 1. Resident #42 and resident #18 still reside in the facility. Resident #68 no longer resides in the facility. Pest control exterminated all areas identified and shower rooms were cleaned on both units. The shower room floor tiles will be repaired. 2. Current residents in the facility have the potential to be affected. An audit by the maintenance director conducted to identify if any other shower rooms floor tiles need repair to prevent accidents, hazards or injury and a caution sign placed on any identified areas. The housekeeping conducted an audit to ensure both shower rooms were on a cleaning schedule and as needed. 3. The Administrator or designee educated the maintenance director and the environmental services director on the process for identifying maintenance repair to prevent accident, hazards and injury, placing caution signs, process for repairs, work orders, pest control book and process, cleanliness of facility, shower rooms and informing the Administrator if outsource vendors are needed to correct items. The SDC or designee will educate the facility staff on cleanliness of the facility, environmental services cleaning schedules and as needed, shower rooms cleaned and disinfected by environmental services, between resident showers by	

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F 689	Continued From page 81 on the tile. The maintenance director stated he was not aware of the tiles being broken. On the afternoon of 09/26/2023, an interview was conducted with CNA D who stated she was aware of the broken tiles and had complained about it to the nurse. She stated that they had reported the broken tiles "a month or so ago." On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concern. No further information was provided.	F 689	CNAs to prevent transmission of infection and communicable transmission, and on the process to prevent accidents and hazard that posed a risk for injury such as the broken shower floor tiles , submission of work orders for maintenance repairs and/or removal of broken shower floor tiles and place caution sign in area to prevent accidents and injury and process for pest sightings writing in pest control book with follow up by maintenance and pest control company . 4. The maintenance director or designee will audit weekly x 4 then monthly x 2 months to verify work orders are received and completed and review pest control with identified areas treated with follow up completed as required and the administrator notified for delay in repairs or outsource vendor required for repair. The environmental service director will audit weekly x 4weeks then monthly x 2 months the shower rooms are cleaned on both units and observe 10 residents□ room to verify clean and disinfected as scheduled. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 5. Date of compliance: 11/19/2023	
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,	F 692		11/19/23

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F 692	Continued From page 82 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 observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure residents maintain acceptable parameters of nutritional status for 3 residents (Residents #22, #53 and #19) in a survey sample of 48 residents. The findings included. 1. For Resident #22, the facility staff failed to ensure the resident did not sustain a significant weight loss. On 09/25/2023 at approximately 2:00 p.m., Resident #22 was interviewed and stated, "The food is horrible, and they never give what is actually on the ticket. They don't care if I eat or not, I have lost weight being in here."	F 692	F692 Nutrition/Hydration Status Maintenance 1. Resident #22 still resides in the facility. Timeframe has passed to correct. Resident #22 weights are indicating gains with continued supplements. RD assessed weights on 11/9/2023. Resident #19 still resides in the facility. Resident #19 had a nutritional assessment by registered dietitian with diet texture change with supplements per physician orders and hydration risk updated on care plan 11/9/2023. Resident #53 no longer resides in the facility. 2. Current residents in the facility have the	

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F 692	Continued From page 83 A review of the clinical record revealed that on admission to the facility on 05/03/2023, Resident #22 weighed 175 lbs. 3 months later on 08/09/2023, Resident # 22 weighed 154 lbs., which is a 12% weight loss (21 lbs.) in 3 months' time. A review of the care plan revealed the following: "FOCUS: Resident is at risk for weight fluctuations related to recent hospitalization, BMI, pressure ulcers, Incomplete Lesion of L1 Lumbar Spinal Cord, Paraplegia, Hereditary and Idiopathic Neuropathy, Necrotizing Fasciitis, Colostomy, Psychoactive Substance Abuse, Anemia, malnutrition. date initiated: 5/3/23 Revision on 9/29/23 [Note revision Resident #22 was interviewed] GOAL: The resident will have optimal nutrition and hydration status thru review period Date Initiated: 05/03/2023 Revision 9/26/23. INTERVENTIONS: Diet as ordered Date Initiated: 09/26/2023 Created on: 09/26/2023. Encourage to eat Date Initiated: 05/09/2023 Created on: 05/09/2023. Meds as ordered Date Initiated: 09/26/2023 Created on: 09/26/2023. RD consult as needed Date Initiated: 05/03/2023 Created on: 05/03/2023. Record meal % intake Date Initiated: 05/03/2023 Created on: 05/03/2023. Review dietary preferences with the resident as needed Date Initiated: 06/07/2023 Created on: 06/07/23.	F 692	potential to be affected. An audit of current residents by the registered dietitian (RD) or designee conducted to identify any other resident with significant weight loss has supplements /interventions as applicable. Findings will be corrected. 3. The Dietary Manager or designee will educate all dietary staff on processes for meal tray preparation with accurate diet, per menu with resident likes and no dislikes. Menu substitutions and logged in menu substitution book and registered dietitian review substitutions menu book on visits. Staff inform dietary if meal tray not accurate and another meal tray prepared. The SDC or designee will educate the licensed nurses, MDS staff, director of activities and activity staff, RD, speech therapist on the process for accurate diet, per menu and residents likes and dislikes with verification of meal tray accuracy prior to delivery of meal tray to resident. Dietary will be informed if not accurate and another meal tray prepared. Identification of significant change meets criteria to for MDS significant change. RD will review weights, complete nutritional assessment with identified residents at risk for weight loss or with significant weight loss with supplements as applicable per physician order. CNAs,	

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F 692	Continued From page 84 Supplements as ordered Date Initiated: 09/28/2023 Created on: 09/28/2023. Weights as ordered Date Initiated: 05/09/2023. A review of the clinical record revealed the following excerpts from the Registered Dietician Admission note dated 05/03/2023: "Height: 70 inches, IBW (ideal body weight) =166.0# Weight: 5/3/2023=175.0# (Hosp wt. 175#) BMI: 25.1 Nutrition risk potential for weight fluctuations r/t recent hospitalization, Incomplete Lesion of L1 Lumbar Spinal Cord, Paraplegia, Hereditary and Idiopathic Neuropathy, Sepsis, Necrotizing Fasciitis, Colostomy, Psychoactive Substance Abuse, Anemia in CKD Nutrition Prescription / Interventions (I): Add MVI with Minerals to aid in wound healing Monitor / Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." The following excerpt is from the Registered Dietician's quarterly note dated 06/06/2023: "Diet: Regular diet, Regular texture, Thin Liquids consistency - Po intake: 76-100% of most meals Supplement: none Skin: pressure area to Sacrum per 5/30/2023 Skin Observation Tool Labs: none Pertinent Meds: Morphine Sulfate, Famotidine, Ondansetron HCl, Gabapentin, MVI with Minerals, Oxycodone HCl Height: 70 inches, IBW (Ideal Body Weight) =166.0# Weight: 5/3/2023=175.0# (Hosp wt. 175#) BMI: 25.1 Continue current interventions Monitor / Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." The following Registered Dietician note was entered during the survey:	F 692	licensed nurses, or speech therapist will provide feeding assistance for identified residents that required to be fed, cueing or need assistance. If resident wear dentures are placed when eating. Report to nurse of resident does not eat with documentation. Pest sighting place in pest control book. 4. Dietary manager will conduct observation audit weekly x 4 weeks the monthly x 2 months of dietary staff preparing 10 meal trays for accuracy of diet, menu items prepared with likes and no dislikes on meal tray. Any findings will be immediately corrected. The unit manager will audit 10 10 meal trays being served to verify accuracy of diet, menu items, likes and no dislikes on meal tray. Any findings will be corrected. DON or designee will audit weekly x 4 weeks then monthly x 2 months to verify resident with significant weight loss have RD nutrition assessment with supplements as applicable per physician order and care plan updated, conduct observation audits on 10 residents that require assistance with eating to verify are being fed. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random	

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F 692	Continued From page 85 "9/29/2023 6:33 AM -Nutrition/Dietary Note: Note Text: Spoke with resident 9/27/2023, requested supplement change from Med Plus to Mighty Shake q day at 2pm. Residents goal weight is ~160.#. Weights now appear stable at goal, resident refused monthly weight. Continues consuming current diet well. Monitor /Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." On 09/29/2023 at approximately 3:00 p.m., an interview was conducted with Resident #22. He was asked if he was trying to lose weight, and he stated he was not and now they are giving him mighty shakes to gain back what he lost. On 10/4/23 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided. 2. For Resident #53, the facility staff failed to ensure the resident did not sustain a significant weight loss. Resident #53 was admitted to the facility on 08/01/2023 weighing 130 lbs. On 09/25/2023, Resident #53 weighed 119 lbs. this is a weight loss of 8.4% (11lbs) in little over a month. A review of the care plan read as follows: "FOCUS: Resident is at risk for weight loss or malnutrition related to recent hospitalization, mechanically altered diet, Encephalopathy, HIV, Opioid Dependence, Cerebral Infarction, Dysphagia, Chronic Hepatitis Date Initiated: 08/07/2023 Created on: 08/07/2023.	F 692	basis. 5. Date of compliance:11/19/2023	

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F 692	Continued From page 86 GOAL: The resident will have optimal nutrition and hydration status thru review period Date Initiated: 08/07/2023 Created on: 08/07/2023. INTERVENTIONS: Assist with meals as needed and observe for any difficulty eating/swallowing Date Initiated: 08/10/2023 Created on: 08/10/2023. Diet/fluids as ordered Date Initiated: 08/10/2023 Created on: 08/10/2023. Encourage to eat Date Initiated: 08/07/2023 Created on: 08/07/2023. RD consult as needed Date Initiated: 08/07/2023. Record meal % intake Date Initiated: 08/07/2023 Created on: 08/07/2023. Review dietary preferences with the resident as needed Date Initiated: 08/10/2023 Created on: 08/10/2023. Supplements as ordered Date Initiated: 08/07/2023 Created on: 08/07/2023. Weights as ordered Date Initiated: 08/07/2023 Created on: 08/07/2023." A review of the clinical record revealed that Resident #53 had only been seen by the Registered Dietician on one occasion, 08/07/2023. Excerpts are as follows: "8/7/2023 09:54 Nutrition/Dietary Note: Note Text: Nutrition Assessment (A) Brief Patient Description: 57-year-old male, admitted 8/1/2023 Medical Dx: Encephalopathy, HTN, Asymptomatic HIV, Cardiac Arrhythmia, Rhabdomyolysis, Opioid Dependence, Cerebral Infarction, Dysphagia, Chronic Hepatitis Diet: Regular diet, Dysphagia Mechanically Altered texture, Nectar Thick Liquid consistency Po intake: 50-100% of most meals - Supplement:	F 692		

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F 692	Continued From page 87 Ensure Nutrition Shake BID." Height: 67 inches, IBW [Ideal Body Weight] =148.0# Weight: 8/1/2023=130.0# BMI: 20.4 Estimated nutritional needs: 59 kg = 1700-1900 kcal (28-32 kcal/kg), 59-70 gms protein (1.0-1.2 gms/kg), 1700-1900 mL fluid (1 mL/kcal) Nutrition risk potential for weight fluctuations or malnutrition r/t recent hospitalization, mechanically altered diet, Encephalopathy, Asymptomatic HIV, Opioid Dependence, Cerebral Infarction, Dysphagia, Chronic Hepatitis Nutrition Prescription / Interventions (I): Change Ensure Nutrition Shake to Med Plus 2.0 @ 120 mL po BID between meals to allow for increased po intake at meals, mechanically altered diet, malnutrition prevention Monitor / Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." Diet orders for Resident #53 read as follows: "Regular diet, Dysphagia Advanced texture, Thin Liquids consistency Aspiration Precautions; Chin Tuck Diet Active 8/23/2023 8:05 am." On 09/28/2023 at approximately 12:00 p.m., an interview was conducted with Resident #53 who stated he did not like the food at the facility. When asked if anyone had asked him for his preferences or his likes and dislikes he stated, "They might have but that is not what I get." On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided 3. For Resident #19, the facility staff did not	F 692		

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intervene during the significant weight loss of a resident with known dysphagia following a stroke, insulin dependent Diabetes Mellitus, and 3 wounds.

Resident #19 was admitted to the facility on 12/26/2022, and most recently readmitted after hospitalization on 09/19/2023 with diagnoses including, encephalopathy, urinary tract infection, oral cadidiasis, and COVID-19. Resident #19 had a medical history including, stroke, diabetes, and acute gastrointestinal bleeding with resulting acute post hemorrhagic anemia and weakness from the 12/26/2022 admission.

The resident's most recent quarterly Minimum Data Set (MDS) assessment was dated with an assessment reference date of 06/21/2023, and coded Resident #19 as moderately cognitively impaired, required extensive assistance with feeding, coded no wounds nor skin problems, at risk for malnutrition, weight 148.0 lbs (pounds), and no swallowing issues. The assessment was in error as Resident #19 had 2 ongoing long standing foot wounds from an original admission known for years.

It is notable to add that no significant change MDS assessment was completed from Resident #19's readmission from the hospital on 09/19/2023 through the time of survey ending 10/04/2023 (15 days after readmission). Resident #19 had a known significant weight loss before hospitalization, and a new pressure sore on the resident's right buttock was found on the day of readmission at unstageable due to slough in the wound bed. These issues would require further nutritional support for wound healing and significant weight loss. According to the

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F 692	Continued From page 89 regulation, a significant change assessment should be conducted within 14 days of a known decline in 2 or more areas such as unplanned weight loss and a new unstageable pressure wound. On 01/02/2023, the Registered Dietician (RD) evaluated the resident and documented: "Nutrition Assessment (A).....Diagnoses.... regular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none, ...pressure wound, medications named...., Nutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated, "Nutrition Assessment (A) quarterly ARD 6-21-23 .....Diagnoses...regular diet regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications named...., continue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. weight 148.3 lbs (pounds)." On 09/07/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began on	F 692		

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09/25/2023 and ended on 10/04/2023. Resident #19's weight document was reviewed and revealed the following:

1. 07/03/2023 - 145.0 pounds
2. 08/07/2023 - 140.2 pounds (5 pound weight loss in one month begins)
3. 09/06/2023 - 131.6 pounds (now a 14 pound (10 %) weight loss in 2 months)
4. 09/11/2023 - 129.0 pounds (now a 16 pound weight loss 9 weeks) Resident #19 went out to the hospital on 09/16/2023 and returned on 09/19/2023.
5. 09/19/2023 - 135.0 (a 6 pound weight gain during hospitalization)
6. 09/25/2023 - 126.0 pounds (a 9 pound weight loss begins again)
7. 09/27/2023 - 119.4 pounds (now almost 20% weight loss in less than 4 months) and weight loss continues.

Physician and RD orders were reviewed and revealed that from 01/03/2023, multivitamin was ordered and discontinued on 06/30/2023, the regular diet was discontinued on 06/30/2023, and the Ensure Compact supplement was discontinued on 06/01/2023. The Med Plus 2.0 supplement was started on 06/01/2023, and discontinued on 06/30/2023.

There were no orders for supplements after the 06/30/2023 discontinuance until 09/19/2023 after a significant weight loss had occurred and been ongoing for months. The multivitamin, and Med Plus 2.0 were restarted on 09/19/2023; however, the Med Plus 2.0 supplement was discontinued nine days later on 09/28/2023 by a physician's order. Weekly weights were obtained beginning 09/06/2023, indicating knowledge of the

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F 692	Continued From page 91 significant weight loss (10 days) before hospitalization on 09/16/2023 for Resident #19; however, no interventions were added for the weight loss. The medication administration record (MAR) documented that the Med plus 2.0 was given daily after 09/228/2023, even after being discontinued, and on 09/28/2023, the diet was changed to mechanically altered, which dietary staff indicated meant chopped. Resident #19 did not receive supplements from 06/30/2023 until 09/19/2023 during a significant weight loss, and the RD did not evaluate nor intervene during a significant weight loss. Resident #19's nutrition care plan, completed and initiated on 01/02/2023, was canceled on 09/18/2023 by the RD. No new nutrition care plan nor any other care plan had been completed at the time of survey on 09/25/2023, nor through 09/27/2023 (9 days after readmission) when documents were obtained. The new readmission care plan was "in development" according to staff nurses when asked to review the care plan in the electronic clinical record. Resident #19 did not have a dehydration care plan even though the resident had experienced dehydration in the facility and received Clysis fluid resuscitation instilled subcutaneously on several occasions. Resident #19 did not receive diuretic medications, which remove fluid from the body. Activities of Daily Living (ADL) records were reviewed and revealed that the Resident needed to be assisted and received extensive assistance. The Resident consumed varying amounts of	F 692		

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F 692	Continued From page 92 meals from 0% to 75%. Family interviews to include the Resident's daughter, and granddaughter, who stated she was an Licensed Practical Nurse (LPN), revealed that Resident #19 had to be fed and will at times accept things in her hands to eat, such as sandwiches; however, she must be cued to eat them. The family was very involved with the resident's care and were there in the facility almost every day. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since the resident was readmitted on 09/19/2023, and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being assisted by one staff member to set up and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. The resident was not eating and CNA (Certified Nursing Assistant) D who was sitting with the residents stated she would be feeding Resident #19. Observations were continued and only one teaspoonful of potatoes was placed up to Resident #19's mouth, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to	F 692		

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F 692	Continued From page 93 have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to the resident. At 1:15 p.m., CNA D was interviewed and asked why she had not fed Resident #19. CNA D stated "She (Resident#19) was very sleepy so I told the nurse (LPN D) and didn't offer her any more food. LPN (Licensed Practical Nurse) D was interviewed and stated, "the speech therapist was changing the resident's diet" and Resident #19 "would receive another tray, but the resident has thrush so she probably won't eat anyway." The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated "she didn't tell me that." The resident was observed for the rest of the shift, and never received another tray. It is notable to mention Resident 19's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. On 09/29/2023 at approximately 1:15 p.m., Resident #19's room was entered with CNA D, in the search for Resident #19's dentures which were missing. The resident had 3 plastic denture cups; however, all three were empty. One cup was in the floor behind the headboard of the resident's bed, one was in the large lower door of the bedside cabinet, and the third was in the upper drawer of the bedside cabinet. When the cabinet door and drawer were opened cockroaches ran out (approximately 5-10 insects) and all over the sides and top of the bedside cabinet. CNA D stated she would have maintenance come immediately and spray the area with insecticide. The dentures were not found in the room nor in the medication cart.	F 692		

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F 692	Continued From page 94 On 09/29/2023 at the end of day debriefing, conducted with the Administrator and Regional Director of Operations, they were notified of findings for Resident #19. On 10/04/2023 at approximately 2:00 p.m., the Administrator, Corporate Nurse Consultant, and Regional Director of Operations were again notified of findings, and they stated they had nothing further to provide.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide respiratory care, consistent with professional standards of practice, for 2 residents (Residents #37 and #71) in a survey sample of 46 residents. The findings included: 1. For Resident #37, the facility staff failed change the nebulizer tubing three times per week as ordered and as per the facility's protocol.	F 695	F695 Respiratory/Tracheostomy Care and Suctioning !! 1. Resident #37 and resident #71 no longer reside in the facility. 2. Current residents in the facility have the potential to be affected. An audit by the unit managers to verify resident receiving jet nebulizer the tubing was changed. 3. The DON will inform the medical providers of the facility policy regarding changing jet nebulizer tubing every week , if the medical provider	11/19/23

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F 695	Continued From page 95 On 09/25/2023 during the initial tour of the building at approximately 12:50 p.m., there was an observation of a nebulizer machine on the bedside table and the tubing and mouthpiece were in a bag that was dated 09/07/2023. Review of the clinical record was conducted on 09/25/2023 and 09/26/2023. Review of Resident #37's physician's orders revealed the following: 07/23/2021 - Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3 ML (3 milligrams per 3 milliliters) 3 ml inhale orally every 4 hours as needed for SOB (Shortness of Breath) or wheezing via nebulizer. 11/10/2022 - Nebulizer tubing setup change M-W-F (Night Shift) every night shift every Mon,Wed, Fri for infection prevention. On 09/25/2023 at approximately 2:00 p.m., an interview was conducted with Licensed Practical Nurse (LPN C) who stated that night shift was supposed to change and date tubing for Nebulizer on Mondays, Wednesdays, and Fridays and change oxygen tubing weekly. She stated the nurse should label and date the tubing when opened and used. When asked about the risks of not changing the tubing as ordered or by the protocol, LPN-C stated there was a risk of infection. On 09/26/2023 at approximately 2:45 p.m., an interview was conducted with Registered Nurse (RN) B who stated that the nebulizer and oxygen tubing should be dated and stored at the bedside. RN-B stated the nebulizer tubing should be	F 695	does not agree then the jet nebulizer will be changed per the frequency of the medical provider order. 4. The SDC or designee will educate the licensed nurses on the policy and process for jet nebulizer and oxygen tubing changes for infection control prevention. The jet nebulizer tubing is change weekly per policy. A physician order is not required to change medical equipment tubing, place on care plan for tubing changes. The DON will inform the medical providers of the facility policy regarding changing jet nebulizer tubing every week , if the medical provider does not agree then the jet nebulizer will be changed per the frequency of the medical provider order. 5. The unit manager or designee will audit weekly x 4 weeks then monthly x 2 months to verify jet nebulizer tubing was changed weekly. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 6. Date of compliance: 11/19/2023	

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F 695	Continued From page 96 changed every Monday, Wednesday and Friday on the night shift. RN-B stated Resident #37 had an order for nebulizer treatments as needed. When asked if the nebulizer equipment and tubing at the bedside was available for use, RN-B stated "Yes, but I hope the nurses would check the date prior to using it." RN-B stated the tubing should be changed as ordered and as per protocol. During the end of day debriefing on 09/26/2023, the Facility Administrator, Director of Nursing and Corporate Nurse Consultant were informed of the findings. A copy of the Facility's Policy on Respiratory Care was requested and received on 09/27/2023. Review of the facility's Respiratory Care Policy and Procedure, effective date 08/04/2015, page 155, number 5 included the excerpt: "Nebulizers and bags must be changed every Monday, Wednesday and Friday and dated." Another copy of the facility Policy on Respiratory Care entitled "Respiratory/Oxygen Equipment, Effective date: 3/13/2023" was presented to the surveyor on 09/28/2023. Review of the policy revealed documentation under "medicated Nebulizer Treatment" number 5 stated:.."Nebulizers and bags should be changed weekly." Another copy of the facility Policy on Respiratory Care entitled "Respiratory/Oxygen Equipment, Effective date: 3/13/2023" was presented to the surveyor on 09/28/2023. Review of the policy revealed documentation under "medicated Nebulizer Treatment" number 5	F 695		

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F 695	Continued From page 97 stated:.."Nebulizers and bags should be changed weekly." No further information was provided. 2. For Resident #71, the facility staff failed to change the nebulizer tubing three times per week as ordered and as per the facility's protocol. On 09/25/2023 during the initial tour of the building at approximately 12:50 p.m., there was an observation of a nebulizer machine on the bedside table and the tubing and mouthpiece were in a bag that was dated 09/09/2023. On 09/26/2023 at 9:30 a.m., another observation was made of the nebulizer with tubing and mouthpiece in a bag dated 09/09/2023. Review of the clinical record was conducted on 09/25/2023 and 09/26/2023. Review of Resident #71's physician's orders revealed the following: 07/23/2021- Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3 ML (3 milligrams per 3 milliliters) one tablet inhale orally every 4 hours as needed for SOB (Shortness of Breath). 11/10/2022- Nebulizer tubing setup change M-W-F (Night Shift) every night shift every Mon,Wed, Fri for infection prevention. On 09/25/2023 at approximately 2:00 p.m., an interview was conducted with Licensed Practical Nurse (LPN C) who stated that night shift was supposed to change and date tubing for	F 695		

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F 695	Continued From page 98 Nebulizer on Mondays, Wednesdays and Fridays and change oxygen tubing weekly. She stated the nurse should label and date the tubing when opened and used. When asked about the risks of not changing the tubing as ordered or by the protocol, LPN-C stated there was a risk of infection. On 09/26/2023 at approximately 2:45 p.m., an interview was conducted with Registered Nurse B who stated that the nebulizer and oxygen tubing should be dated and stored at the bedside. RN-B stated the nebulizer tubing should be changed every Monday, Wednesday and Friday on the night shift. During the end of day debriefing on 09/26/2023, the facility Administrator, Director of Nursing, and Corporate Nurse Consultant were informed of the findings. A copy of the facility's Policy on Respiratory Care was requested and received on 09/27/2023. Review of the facility's Respiratory Care Policy and Procedure, effective date 08/04/2015, page 155, number 5 included the excerpt: "Nebulizers and bags must be changed every Monday, Wednesday and Friday and dated." Another copy of the facility Policy on Respiratory Care entitled, "Respiratory/Oxygen Equipment, Effective date: 3/13/2023" was presented to the surveyor on 09/28/2023. Review of the policy revealed documentation under "medicated Nebulizer Treatment" number 5 stated:.."Nebulizers and bags should be changed weekly."	F 695		

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F 695	Continued From page 99 No further information was provided.	F 695		
F 699 SS=G	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure that residents who are trauma survivors receive trauma-informed care to mitigate triggers for 2 residents (Residents #22 and #53) in a survey sample of 48 residents. The findings included: 1. For Resident #53, the facility staff failed to provide trauma-informed care for a resident who has experienced sexual assault by CNA C at the facility. Resident #53 was admitted to the facility on 08/01/2023 with diagnoses that include but are not limited to schizoaffective disorder, hemiplegia after CVA (Cerebrovascular Accident or stroke) right sided, HIV (Human Immunodeficiency Virus), Hepatitis C, and Hypertension. A review of the clinical record revealed the following:	F 699	F699 Trauma Informed Care !! 1. Resident #53 no longer resides in the facility. Resident #22 still resides in the facility. Resident #22 received psych services 11/1/2023. 2. Current residents with PTSD (Post Traumatic Stress Disorder) diagnosis in the facility have the potential to be affected. An audit by the DON or designee conducted to verify residents with diagnosis of PTSD or Trauma Informed Care completed with identified trauma have a care plan identify problem with triggers to avoid staff triggering feelings from past trauma and causing emotional distress or emotional harm. 3. The Administrator or designee will educate social service /discharge planner staff and nursing management DON, unit managers on documentation and completion of trauma informed care,	11/19/23

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F 699	Continued From page 100 "8/10/2023 5:06 pm Transfer to Hospital Summary Note Text: Patient sent to [Hospital Name redacted] for evaluation r/t alleged assault, MD made aware. Patient verbalized understanding the reason for transfer." "8/10/2023 - 5:15 pm Health Status Note Text: Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 pm at the south unit nursing station. Phone call placed to nonemergent services so patient could give an official statement and press charges." "8/12/2023 4:51 - Alert Note Text: Due to safety concerns r/t behavioral issues; constant yelling and threatening staff to throw himself out of the bed when in room/bed. Administration made aware to possibly consider moving room closer to nurses' station." "8/15/2023 2:41 pm COMMUNICATION - with Resident Note Text: [name redacted] and [name redacted] spoke with [Resident #53] about his feelings today 8/15/23. Therapy reported that [Resident #53] wants to harm self, to which [Resident #53] admitted. [Resident #53] says that he can come up with a plan to harm himself [name redacted] made Dr. [name redacted] (psych) aware." "8/17/2023- 5:50 AM - Health Status Note-Note Text: Per reports, resident was suicidal during the day shift. Hourly checks done on resident throughout the shift, resident stated he had no plan or intention to commit suicide. During multiple encounter, resident was noted to be impatient, combative towards staff such as throwing water at care staff or yelling for not	F 699	care plan for PTSD diagnosis with triggers and trauma identified on the trauma informed screening and care plan with triggers to attempt to avoid staff triggering feelings from past trauma and causing emotional distress or emotional harm. if applicable. The SDC or designee will educate all facility staff on PTSD and triggers to avoid preventing behaviors and/or emotion harm associated with triggering events from past or current trauma. Management, monitoring, preventing behaviors and avoiding triggers that may cause risk for or actual emotional harm for residents with behavioral healthcare needs and residents with substance abuse. Identified residents will have care planned with problem and triggers to attempt avoid staff triggering feelings from past trauma and causing emotional distress or emotional harm. 4. The Director of discharge planner or designee will audit weekly x 4 weeks then monthly x 2 months to verify residents with PTSD diagnosis, behavioral healthcare needs, substance abuse or trauma identified on the trauma informed care form have a care plan with problems and trigger to avoid staff triggering feelings from past trauma and causing emotional distress or emotional harm. Results of the review will be	

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F 699	Continued From page 101 providing him with his needs as soon as he asked for them. Nurse provided education that he needs to give staff time to respond, also he needs to communicate with his words rather than violently/physically attempting to hit staff. Incontinent care provided every 2 hours and as needed, fall precautions followed and maintained, he is stable and resting in bed at this time." On 09/27/2023 and interview was conducted with the DON who was asked if they have psych services in the building and she stated that they did. When asked if she thought it would be beneficial for Resident #53 to have seen psych services after such an incident, she stated that she thought he did and would supply the notes from psych services. A review of the clinical record revealed that Resident #53 had an order dated 08/01/2023 that read, "Psych Consult as needed" however, was not seen by psych services until 08/23/2023. The visit on 08/23/2023 was not prompted by the sexual assault. A review of the psych notes revealed the following: "Resident was referred today for stabilization in depressed mood. Per nurses' notes and report, resident is reported to be verbally abusive to staff, and refusing care sometimes, Resident was met in his room, in bed, calm, alert, speech clear and engaged. Resident reported in on multiple psychotropic medications to include Lithium, Haldol, Risperidone, Diazepam, Ativan, Methadone, Seroquel, Hydroxyzine and Trazadone. Reported he has not been sleeping well a night. "I stay awake the whole night; I cannot sleep." Resident also reported he feels "sad and depressed."	F 699	presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 699	Continued From page 102 On 08/23/2023 after the psych visit, the order was given for Trazadone 50mg for insomnia. On 09/28/2023 at 11:00 a.m., an interview was conducted with the Staff Development Coordinator who was asked about training for PTSD, she stated they do not tell me to train on that subject. When asked if she trained on trauma-informed care, she stated that she did not. When asked if she trained on behavioral healthcare needs related to substance abuse, she stated that she did not. When asked does your staff care for residents in this facility with any or all those issues and she stated that they do. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided. 2. For Resident #22, the facility staff failed to provide trauma-informed care for a resident diagnosed with Post Traumatic Stress Disorder (PTSD). Resident #22 was admitted to the facility on 05/02/2023 with diagnoses that include but are not limited to incomplete paraplegia, PTSD, peripheral neuropathy, anxiety, history of substance abuse and smoking. On 09/25/2023 at approximately 1:00 p.m., an interview was conducted with Resident #22 who stated the facility "Does not know how to deal with us, I have PTSD and they don't know how to talk to me." When asked to elaborate, he stated the facility staff are loud and rude and that "triggers"	F 699		

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F 699	Continued From page 103	F 699		
	him to become "aggressive." When asked if he has told anyone about this, he stated he has spoken to the DON and the Administrator about it, but nothing is done. Resident #22 also stated he had a substance abuse problem prior to coming to the facility and that the facility staff "use that information against me." When asked what he meant by that, he stated the facility staff "downplay" his pain because he had a substance abuse issue prior to coming to the facility. He stated the staff have labeled him as "drug seeking." On 09/28/2023 at 11:00 a.m., an interview was conducted with the Staff Development Coordinator who was asked about training for PTSD, she stated they do not tell me to train on that subject. When asked if she trained on trauma-informed care, she stated that she did not. When asked if she trained on behavioral healthcare needs related to substance abuse, she stated that she did not. When asked does your staff care for Residents in this facility with any or all those issues and she stated that they do. On 10/04/2023 during the end of the day debriefing, the Administrator was made aware of the concerns. No further information was provided.			
F 726 SS=G	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726		11/19/23

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F 726	Continued From page 104 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and facility documentation review, the facility failed to ensure 5 of 5 nursing staff members (Staff #6, Staff #21, Staff #22, Certified Nursing Assistant [CNA]-H and CNA-K) in the sample were competent to provide care to the facility's resident population, resulting in psychological harm for Resident #22. Findings included:	F 726	F726 Competent Nursing Staff !! 1. Resident #22 still resides in the facility. Resident #22 received psych services 11/1/2023. SDC initiated education and training for all facility staff on PTSD (Post traumatic stress disorder) with triggers on 9/27/2023. 2. Current residents in the facility have the potential to be affected. The DON or designee will	

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F 726	Continued From page 105 The facility staff failed to ensure nursing staff had the competencies including knowledge, skills, and abilities, necessary to meet the resident's needs when diagnosed with trauma/Post-traumatic Stress Disorder (PTSD) in accordance with the facility assessment, resulting in expression of psychological harm for Resident #22. During the initial tour of the facility on 09/25/2023 at 11:50 a.m., Resident #22 approached the surveyors (Surveyor C and Surveyor D) and stated he had PTSD, and the facility staff "did not know how to take care of people diagnosed with PTSD." Resident #22 stated he was upset about it. He stated he "really was diagnosed with PTSD. They (facility staff) act like they don't know how to handle it (PTSD)." Resident #22 stated the staff treated him as if he was "pretending." Resident #22 stated "this is serious." The resident stated he did not feel understood by the staff. Resident #22 discussed his feelings more in depth with Surveyor D during the survey. On 09/26/2023 at 9:05 a.m., an interview was conducted with Licensed Practical Nurse B who stated there were residents in the facility who had diagnoses of PTSD and other behavioral health conditions. LPN-B stated she had not received specialized training on caring for residents with trauma/PTSD. On 09/27/2023 at 12:55 p.m., an interview was conducted with Certified Nursing Assistant-L who stated she had not received any special training on caring for residents with trauma/PTSD. Review of the Facility Assessment revealed a review date of 08/31/2023. The facility assessment, Part 2. Services and Care Offered	F 726	conduct an audit from 10/4/2023 on residents that have a PTSD diagnosis or have identified trauma on the Trauma Informed Screening to verify were not effected by the staff triggering feelings of past trauma or causing aggressive behaviors emotional distress or emotional harm. 3. The SDC or designee will educate and training for all facility staff on PTSD and triggers, preventing behaviors and/or emotional harm associated with triggering events from past or current trauma. Management, monitoring, preventing behaviors and avoiding triggers that may cause risk for or actual emotional harm for residents with behavioral healthcare needs and residents with substance abuse. Identified residents will have care planned with problem and interventions it identify triggers to attempt to avoid/ prevent emotional distress / emotional harm and understand how to care for, manage and respond to the resident if triggered with feelings from past trauma or exhibiting aggressive behaviors to help with coping skills, to calm and empower resident to express feelings and promote trust to prevent further emotional distress/harm. 4. The DON or designee will audit weekly x 4 weeks then monthly x 2 months to verify for new	

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F 726	Continued From page 106 Based on Resident Needs (on page 1 of 2) Section 2.1 General Care and Specific Care or Practices" listed the general care area of "Mental Health and Behavior" and under "Specific Care or Practices" was written, "Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with...trauma/PTSD, other psychiatric diagnoses..." On 09/27/2023 at 2:15 p.m., an interview was conducted with the Staff Development Coordinator who stated she provided in-service education and training to the facility staff members. The Staff Development Coordinator stated staff members also complete computer-based training on required subjects. She stated she was aware the facility accepted residents for admission who were diagnosed with behavioral health issues to include but not limited to mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, or other behavioral health condition and dementia according to the facility assessment. The Staff Development Coordinator stated the facility assessment was utilized to ensure residents could receive the care and services necessary for their well-being. The Staff Development Coordinator stated she was not told to include trauma/PTSD in the training topics but would immediately begin to train on that topic. Review of the 5 sampled employee training records revealed no documentation of training on trauma/PTSD. All 5 staff members were hired in 2022 or 2023 (Staff #6 LPN hired in 2023, Staff	F 726	hires and any identified staff not received had education and training on PTSD, behavioral healthcare management and substance was completed with documentation and care plan reflects triggers to avoid/prevent feelings of past trauma causing emotional distress or emotional harm. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 726	Continued From page 107 #21 hired in 2022, Staff #22 hired in 2022, CNA-H hired in 2023 and CNA-K hired in 2022). During the end of day debriefing on 09/27/2023, the facility Administrator, Director of Nursing, and Corporate Nurse Consultant were informed of the findings of no behavioral health training on trauma/PTSD. They were informed that none of its staff members had received any training/education or met competencies regarding the provision of care to residents diagnosed with trauma/PTSD. The residents' needs were not being met in order for them to reach their highest potential. On 09/28/2023, the Staff Development Coordinator provided a copy of the training curriculum including topics covered during orientation and training sessions. Review of the curriculum revealed there was no documentation of the topic of trauma/PTSD (Post-traumatic Stress Disorder. During the end of day debriefing on 10/03/2023, the facility Administrator, Director of Nursing, Corporate Nurse Consultant, and Vice President of Operations were informed of the findings. They were informed by Surveyor D that one resident expressed feelings of psychosocial harm. No further information was provided.	F 726		
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1)	F 742		11/19/23

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F 742	Continued From page 108 A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure residents who display or are diagnosed with mental disorder, or history of Post-traumatic Stress Disorder (PTSD) receives appropriate treatment and services to attain the highest practical mental and psychosocial well-being for 1 resident (Resident #53) in a survey sample of 48 residents. The findings included: For Resident #53, the facility staff failed to ensure the resident received appropriate services post sexual assault by a staff member at the facility. Resident #53 was admitted to the facility on 08/01/2023 with diagnoses that include but are not limited to schizoaffective disorder, hemiplegia after CVA (Cerebrovascular Accident or stroke) right sided, HIV (Human Immunodeficiency Virus), Hepatitis C, and Hypertension. A review of the clinical record revealed the following: "8/10/2023 5:06 pm Transfer to Hospital Summary Note Text: Patient sent to [hospital Name redacted] for evaluation r/t alleged assault, MD made aware. Patient verbalized	F 742	F742 Treatment/Svrcs Mental/Psychosocial Concerns 1. Resident #53 no longer resides in the facility. 2. Current residents in the facility have the potential to be affected. An audit by the DON or designee to verify residents with mental disorder or PTSD (post-traumatic stress disorder) diagnosis have psych services ordered per physician had psych services visits. 3. The SDC or designee will educate social service/discharge planners and licensed nurses on the process for psych services per physician order for residents with mental disorders, PTSD, substance abuse or trauma and verify psych services visits occur. Discharge planners and licensed nurses will assess, monitor for psychosocial wellbeing changes, emotional distress and/or emotional harm with MD and RP notification and documentation. 4. The unit manager will audit weekly x 4 then monthly x 2 months to verify residents with mental disorder or PTSD have psych service per	

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F 742	Continued From page 109 understanding the reason for transfer." "8/10/2023 - 5:15 pm Health Status Note Text: Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 pm at the south unit nursing station. Phone call placed to nonemergent services so patient could give an official statement and press charges." "8/12/2023 4:51 -Alert Note Text: Due to safety concerns r/t behavioral issues; constant yelling and threatening staff to throw himself out of the bed when in room/bed. Administration made aware to possibly consider moving room closer to nurses' station." "8/15/2023 2:41 pm COMMUNICATION - with Resident Note Text: [name redacted] and [name redacted] spoke with [Resident #53] about his feelings today 8/15/23. Therapy reported that [Resident #53] wants to harm self, to which [Resident #53] admitted. [Resident #53] says that he can come up with a plan to harm himself [name redacted] made Dr. [name redacted] (psych) aware." "8/17/2023- 5:50 AM -Health Status Note-Note Text: Per reports, resident was suicidal during the day shift. Hourly checks done on resident throughout the shift, resident stated he had no plan or intention to commit suicide. During multiple encounter, resident was noted to be impatient, combative towards staff such as throwing water at care staff or yelling for not providing him with his needs as soon as he asked for them. Nurse provided education that he needs to give staff time to respond, also he needs to communicate with his words rather than	F 742	physician orders and psych service visits occurred with documentation. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 742	Continued From page 110 violently/physically attempting to hit staff. Incontinent care provided every 2 hours and as needed, fall precautions followed and maintained, he is stable and resting in bed at this time." On 09/27/2023, an interview was conducted with the DON who was asked if they have psych services in the building and she stated they did. When asked if she thought it would be beneficial for Resident #53 to have seen psych services after such an incident, she stated she thought he did and would supply the notes from psych services. A review of the clinical record revealed that Resident #53 had an order dated 08/01/2023 that read "Psych Consult as needed"; however, the resident was not seen by psych services until 08/23/2023. The visit on 08/23/2023 was not prompted by the sexual assault. A review of the psych notes revealed the following: "Resident was referred today for stabilization in depressed mood. Per nurses' notes and report, resident is reported to be verbally abusive to staff, and refusing care sometimes, Resident was met in his room, in bed, calm, alert, speech clear and engaged. Resident reported in on multiple psychotropic medications to include Lithium, Haldol, Risperidone, Diazepam, Ativan, Methadone, Seroquel, Hydroxyzine and Trazadone. Reported he has not been sleeping well a night. "I stay awake the whole night; I cannot sleep." Resident also reported he feels "sad and depressed." On 08/23/2023 after the psych visit, the order was given for Trazadone 50mg for insomnia.	F 742		

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F 742	Continued From page 111 On 09/28/2023 at approximately 3:00 p.m., Resident #53 was interviewed about the incident on 08/10/2023 involving the sexual assault by CNA C. Resident #53 stated that he was afraid to have male staff anymore. He stated he was unable to sleep at all after the incident and was prescribed Trazadone as a result. Resident #53 was in tears when explaining how the incident made him feel helpless and fearful because he has contractures that prevent him from defending himself. Resident #53 stated he was aware the CNA would no longer be in the building but still did not want any male CNA staff to work with him. When asked if he was provided with emotional support or psych services immediately following the incident, he stated that he did not. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 742		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation, the facility staff failed to provide medically related social services for 1 resident (Resident #22) in a survey sample of 48 residents. The findings included:	F 745	F745 Provision of Medically Related Social Service 1. Resident #22 still resides in the facility. Discharge planner has assisted Resident #22 has received both social security care and state identification card as requested.	11/19/23

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F 745	Continued From page 112 For Resident #22, the Social Worker failed to assist the resident in obtaining his social security card and state identification card that was lost during his hospital admission prior to admission to the facility. On 09/25/2023 at approximately 3:00 p.m., Resident #22 was interviewed and stated he has not had his ID or Social Security card since he came to the facility. He stated it was lost during his hospital admission prior to entering the facility. When asked if he had made the staff aware of the need for assistance, he stated "I made both of the Social Workers aware a few times but a lot of good that does they both quit on Friday." When asked when he told them, he stated, "I have been asking since I got here." A review of the clinical record revealed there was no documentation at all from social services since arriving at the facility on 05/03/2022. On 09/26/2023, an interview was conducted with Employee O who was asked if there are no notes in reference to social services in the chart what does that mean? Employee O stated the social services employees are no longer at the facility. They resigned on the previous Friday, so they could not tell whether Resident #22 had any interaction with them regarding his identification. "9/26/2023 4:00 pm -DISCHARGE PLANNING PROGRESS NOTES Text: [Discharge planner name redacted] called [County Social Services name redacted] service and left a voicemail for [Social worker name redacted] (LTC benefits) requesting information (copy of his ID or birth certification), [Resident #22 name redacted] needs to some type of Identification to replace his	F 745	2. Current residents in the facility have the potential to be affected. An audit by DON or designee to identify if other resident required assistance with identifications. Resident #103 was identified and discharge planner assisting with process to obtain social security card. No other residents were identified. 3. The Administrator or designee will educate the discharge planners to the process for resident right to be assisted with obtaining personal identifications such social security card, state identification card as needed to have available and/or help with retuning to the community. 4. The Director of discharge planner audit weekly x 4 weeks and monthly x 2 months to identify resident that require assistance with obtaining a social security card and/or state identification card were assisted and obtained. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 745	Continued From page 113 lost ID." When asked if a resident who has substance abuse issues, mental health concerns, and a diagnosis of PTSD should have seen the Social Worker at least 1 time since arrival at the facility, she stated, "he should have at least an admission note." On 10/04/2023 during the end of day meeting, the Administrator was made aware. No further information was provided.	F 745		
F 755 SS=D	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	F 755		11/19/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 114 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. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation, the facility staff failed to ensure medications were available for 1 resident (Resident #103) in a survey sample of 48 residents. The findings included: For Resident #103, the facility staff failed to ensure the resident had an adequate supply of Morphine 15mg for her pain control due to a wound. On 09/25/2023 at approximately 4:30 p.m., an interview was conducted with Resident #103 who stated the facility keeps running out of her pain medicine (Morphine 15 mg). When asked if she knew why this was happening, she stated she did not know but "It happened again this morning." She stated the nurse got her an order for Tramadol, but she still has to wait to get that. A review of the clinical record read: "9/25/2023-4:13 pm Health Status - Note Text: Spoke with Resident this AM due to complaints that medication MS every four prn was not available. Spoke with nurse and pharmacy and medication requiring prior authorization. Physician will be in tomorrow to sign PA, in the meantime	F 755	F755 Srvcs/Procedures/Pharmacist/Records 1. Resident #103 still resides in the facility. Resident #103 has medication is available. 2. Current residents in the facility have the potential to be affected. An audit by the DON or designee to review current residents□ medications required hard scripts obtained, ordered, delivered and available to administer per physician order. 3. The SDC or designee will educate licensed nurses on process for timely reordering medication to have delivered and available, hard scripts obtained, medication order, delivered and available to prevent unavailable medications and to administer per physician order. 4. The unit manager or designee audit weekly x 4 weeks then monthly x 2 months to verify medications are reordered or required hard scripts obtained, ordered, delivered and available to administer per physician order. Results of the review will be presented to the QAPI committee for	

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	495193		C 10/04/2023

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F 755	Continued From page 115 new order for Tramadol 50 mg every six hours ordered." A review of the Medication Administration Record (MAR) revealed that Resident #103 did have a valid order for Morphine 15mg every 4 hours for pain. This medication was unavailable. Resident #103 did not receive morphine from 2:51 p.m. on 09/21/2023 until 09/26/2023 at 7:30 a.m. "9/26/2023 05:35 - Orders - Administration Note-Note Text: Tramadol 50mg every six hours routine every 6 hours related to SUBACUTE OSTEOMYELITIS, LEFT ANKLE AND FOOT Medication in route per pharmacy, unable to pull from omnicel at this time, MD aware that medication required script." On the afternoon of 09/26/2023, an interview was conducted with the DON who stated the process for reordering medications is that the staff notify the pharmacy for refills and if it requires a hard script, they contact the physician to get it. The DON was asked if they use a back-up pharmacy, she indicated they did have one but if they do not have a physician hard script they cannot get it from the back-up pharmacy either. When asked who is responsible for ensuring a new script is obtained, she stated the nurses are. On the morning of 09/27/2023, an interview was conducted with LPN B who stated that Resident #103's morphine is not scheduled, it is PRN, so the resident would have to ask for the medication to receive it. When asked if it was available in the cart on 09/25/2023, she stated it was not. When asked if it was in the Omnicell (stat box), she stated it was not. When asked if the Tramadol was available for use, she stated it was in the	F 755	review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 755	Continued From page 116 Omnicell, but needed a script at the time it was ordered because they only had a verbal order. A review of the Medication Administration Record (MAR) for Sept. 2023 revealed that although nurses notes document the Tramadol was unavailable, yet it is signed off as given on 09/25/2023 at 6:00 p.m., and on 09/26/2023 at 6:00 a.m. It was left blank, but at 12:00 noon it was signed off as being given. Resident #103 reports not receiving any ordered Tramadol pain medication until 09/26/2023 at 6:00 p.m. A review of the Resident Council minutes revealed that during the months of March through August, residents complained about medications not being on time and the facility running out of residents' medications. On the morning of 09/27/2023, an interview was conducted with LPN B who stated Resident #103's morphine is not scheduled, it is PRN. The resident would have to ask for the medication to receive it. When asked if it was available on the cart on 09/25/2023, she stated it was not. When asked if it was in the Omnicell (stat box), she stated it was not. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 755		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		11/19/23

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F 803	Continued From page 117 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interview, and facility documentation review, the facility staff failed to prepare the meal in accordance with the menu, which affected the residents residing on 2 of 2 nursing units. The findings included: On 09/25/2023 and 09/26/2023 during the initial tour, a significant number of residents, residing on both nursing units, expressed concern regarding the food to all surveyors.	F 803	F803 Menus Meet Resident Nds/Prep in Adv/Followed 1. Resident #17 still resides in the facility. Resident #65 still resides in the facility. Resident #49 still resides in the facility. Timeframe has passed to correct. 2. Current residents in the facility have the potential to be affected. 3. The Dietary Manager or designee will educate all dietary staff on processes for meal tray	

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F 803	Continued From page 118 On 09/27/2023 during the morning, Surveyor F made observations of several residents' breakfast trays. The findings were as follows: For Resident #17, the meal ticket indicated she was to get scrambled eggs, slivered green onions, biscuit, grits, and sausage gravy. There was a notation at the bottom that the resident requested "Hb Egg" [hardboiled egg]. The meal tray consisted of 2 hardboiled eggs, 2 pieces of toast, and a bowl of oatmeal. During the above observation of Resident #17's meal tray, the resident said, "I don't eat grits, but we never get what is on the ticket." Additional observations were made, which included but were not limited to Resident #65 and Resident #49. Both residents' meal ticket indicated they were to have scrambled eggs, slivered green onions, biscuit, grits, and sausage gravy. Neither of them had any slivered onions, biscuits, grits, or sausage gravy. Both had scrambled eggs, toast, and oatmeal. Resident #49 said, "While you are here and make recommendations, next week it will go back to the same thing, there is no consistency. We never get salt, the toast is burnt on the ends, and we never have sausage gravy." On 09/27/2023, Surveyor F reviewed the menu, which indicated it was "Day 18" and the menu was supposed to be, "Scrambled eggs, slivered green onions, biscuit, grits, and sausage gravy." On 09/27/2023 at 9:20 a.m., Surveyor F conducted an interview with the cook, Employee J. When asked what he had prepared for the	F 803	preparation with accurate diet, per menu with resident likes and no dislikes. Menu substitutions and logged in menu substitution book and registered dietitian review substitutions menu book on visits. The SDC or designee will educate the licensed nurses, and CNAs on the process for accurate diet, per menu and residents likes and dislikes with verification of meal tray accuracy prior to delivery of meal tray to resident. Dietary will be informed if not accurate and another meal tray prepared. 4. Dietary manager will conduct observation audit weekly x 4 weeks the monthly x 2 months of dietary staff preparing 10 meal trays for accuracy of diet, menu items prepared with likes and no dislikes on meal tray. Any findings will be immediately corrected. The unit manager will audit 10 10 meal trays being served to verify accuracy of diet, menu items, likes and no dislikes on meal tray. Any findings will be corrected. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 803	Continued From page 119 meal, Employee J said, "eggs, oatmeal, toast, hard boiled eggs, and sausage." When asked what is the purpose of the meal ticket, the cook stated, "It tell you what they are eating and their diet." The cook was asked to let the surveyor see the menu for the day. The cook pulled out a binder with the menu which listed the biscuits and sausage gravy and oatmeal. When questioned why these items were not prepared, the cook said, "The biscuits didn't come on the truck, we don't do sausage gravy, when you see that on the menu, we do sausage and grits. We changed because they complained they didn't like it anymore." The dietary manager joined Surveyor F and Employee J during the above interview. The dietary manager was asked to allow Surveyor F to see the menu substitution log. The dietary manager was unable to locate the log and indicated she would have to call the evening cook. At the end of the day, the dietary manager confirmed she had never been able to locate the menu substitution log. On 09/27/2023 at 10:08 a.m., the dietary manager (DM), Employee K, and the registered dietician (RD),Employee N, were in the conference room with the survey team. The DM and RD were asked about the process with regarding the residents' meals. The DM said they, at the least, discuss it during Resident Council meetings. The survey team shared the abundance of concerns that residents had shared regarding the food. Surveyor F made the RD aware of the observations from breakfast and asked if she had approved such changes to the menu. The RD said she had just been made aware prior to them coming into the conference	F 803		

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F 803	Continued From page 120 room and the menu had not formally been changed. It was also pointed out that their current menu had been in use since January 5, 2022, and that residents have complained about always getting the same thing. The RD and DM both stated they are working to update menus now. On 09/28/2023 during the breakfast meal observations, it was again noted that the residents were not receiving the meal items that were listed on their meal tickets. On 09/28/2023 during mid-morning, the Administrator was made aware of the above findings and observations regarding the menus not being followed and residents' concerns with the meals. On 09/29/2023 during the mid-day/lunch meal, observations were made of residents' meal trays. Again, it was noted that the items listed on the menu were not being served. Squash casserole was supposed to be served according to the menu, the meal tickets had that item crossed out and broccoli hand-written in, but the residents were served cabbage. On 09/29/2023, the dietary manager presented Surveyor F with a "Dietary Menu Substitution Record" that indicated for the lunch meal, cabbage was added and squash was omitted. The reason for the change was noted as, "Residents choice." There was no indication in any other records reviewed that the residents had requested this change or were previously made aware of the change.	F 803		

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F 803	Continued From page 121 Review of the Resident Council meeting minutes revealed the following: 1. During the August 16, 2023, meeting, Residents expressed, "What is on meal tickets are not served...Wrong diets served." The department's response was, "Dietary staff will alert pt [patient] when there are menu changes." 2. During the meeting held July 21, 2023, residents expressed, "Quality of the food has not improved." 3. In May's meeting, the residents expressed, "Alternate meals and sandwiches are not offered." In the resolution section it was noted, "Reminder, [contracted dietary company name redacted] is only responsible for posted menu items only per Dietary Manager." There was no evidence that the Resident Council had expressed any concerns regarding the sausage gravy, grits, or biscuits. Review of the facility policy titled, "Menus" was conducted. This policy read, "It is the center policy that menus are planned in advance, and to meet the nutritional needs of the residents/patients, will be developed utilizing an established national guideline. 6. Menus are served as written, unless changed in response to preference, unavailability of an items, or a special meal. 7. A menu substitution log will be maintained on file." On 09/28/2023, at the end of the survey day, the facility Administrator was made aware of the above findings. No further information was provided.	F 803		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		11/19/23

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F 804	Continued From page 122 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to serve food that was palatable and hot to residents on 2 of 2 nursing units. Findings include: For residents residing on both nursing units, the facility staff failed to serve food in a manner to ensure the food was at a preferred temperature when it reached the residents. On 09/25/2023 - 09/26/2023 during the initial tour process, an abundance of residents on both nursing units expressed concerns about the food not being hot. On 09/28/2023, observation of breakfast tray distribution was conducted. For residents residing on the North wing, breakfast trays were not served until 10:00 a.m. It was noted that each cart of meal trays held approximately 25-30 meal trays. One entire cart, which served residents in rooms 1-12, were all served in Styrofoam containers, like a restaurant carryout container. Another cart, which served residents in rooms	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp 1. Timeframe has passed to correct. 2. Current residents in the facility have the potential to be affected. 3. The Dietary manager will educate the dietary staff on the process for meal preparation to ensure hot food temperatures are maintained. The SDC or designee will educate CNAs, licensed nurses, department managers on the process to ensure hot food temperatures are maintained, distributed timely, Styrofoam and open carts are delivered prior to meal carts with closed doors until meal trays passed. 4. The dietary manager or designee will audit weekly x 4 weeks then monthly x 2 months temperature checks of 10 meal trays to verified hot food temperature is maintained after serving meal trays. Results of the review will be presented to the QAPI committee for review and	

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F 804	Continued From page 123 13-24, approximately half of the trays were on regular dinnerware plates and the other half were in the same Styrofoam containers. On 09/28/2023 at approximately 10:05 a.m., while breakfast trays were being distributed to residents, interviews were conducted with CNA B and CNA G. When asked about the Styrofoam, their responses were, "They must have run out of plates" and "Sometimes they are all served on Styrofoam." Resident interviews were conducted, and numerous residents complained that the food was not hot. Resident #65 commented that she did not mind the Styrofoam so much as it did not keep the food warm. On 09/28/2023 at approximately 10:25 a.m., Surveyor F went to the kitchen to interview the cook. The cook was asked about the timing of meal trays, and he indicated the last cart had just left the kitchen about 10-15 minutes ago. When asked if this was normal or if something impacted the meals being late this morning, the cook said, "No, everything went smooth, we had no problems." The cook was asked about residents being served on Styrofoam, and he said that they did not have enough clean plates. During the above interview, the dietary manager joined the conversation. The dietary manager stated, "When late trays don't come back to the kitchen timely at night, we can't wash them, and they aren't available in the morning." The dietary manager also stated the food is hot when it leaves the kitchen, but it sits on the floors/halls and when staff do not pass/distribute them timely, the food gets cold. Additionally, she stated that	F 804	recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 5. Date of compliance: 11/19/2023	

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F 804	Continued From page 124 one of the carts has a broken door and will not latch for the South wing, so it allows the heat to escape and that maintenance is going to work on the cart. On 09/29/2023, meal trays for lunch were observed on the South wing and multiple residents again complained that the food was not hot. Review of the Resident Council minutes was conducted. This review revealed a "Service Concern Report" was submitted in April following the Resident Council meeting for food being cold. Review of the facility's dietary policies provided to the survey team were reviewed. The policies did not address the palatability and food temperature at the time of meal delivery. On 09/29/2023, the facility Administrator was made aware of the above findings. No additional information was provided.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16	F 809		11/19/23

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F 809	Continued From page 125 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation, the facility staff failed to provide snacks to residents who wish to eat outside of scheduled meal times. The findings included: For residents who wish to eat outside of regular mealtimes, the facility failed to ensure snacks were available on the units. On 09/26/2023 at approximately 2:00 p.m.,during the Resident Council meeting, 6 of 6 residents agreed that snacks are not available in the evenings. A review of the Resident Council minutes revealed that snacks being unavailable has been brought up in 4 of the last 6 meetings. On 09/28/2023 at 10:00 a.m., an interview was conducted with Employee K who stated that she sends snacks to the floor including cookies, pudding, applesauce, peanut butter crackers, juices, and milk. She stated that she does not know why there is not any left at bedtime. An interview was conducted with CNA G who	F 809	F809 Frequency of Meals/Snacks at Bedtime 1. The Dietary Manager on 9/28/2023 verified snacks were available on both units. 2. Current residents in the facility have the potential to be affected. 3. The Dietary Manager or designee will educate the dietary staff on the process to ensure snacks are available on each unit for the resident. 4. The Dietary Manager or designee at the approval of resident council next resident council meeting to ensure the concerns and plan for snack availability for the residents. The dietary manger or designee will conduct observation rounds weekly x 4 weeks then monthly x 2 months to ensure snacks are available on each unit. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis.	

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STREET ADDRESS, CITY, STATE, ZIP CODE
561 NORTH AIRPORT DRIVE
HIGHLAND SPRINGS, VA 23075

(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 809	Continued From page 126 stated there is hardly ever any snacks for residents. CNA G stated she has worked evenings and they did not have any when she worked. An observation was made of the "pantry" area on each unit on 09/28/2023 at 12:50 p.m., and there were snacks available at that time. Per the Resident Council minutes "pantries should be stocked every shift." On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 809	5. Date of compliance: 11/19/2023	
F 838 SS=G	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions,	F 838		11/19/23

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F 838	Continued From page 127 physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.	F 838		

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F 838	Continued From page 128 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and facility documentation review, the facility staff failed to update the facility assessment to assess the needs of its resident population, the required resources to provide the care and services the residents need resulting in expression of psychological harm by one resident (Resident #22) in the survey sample of 46 residents. Findings included: The facility failed to develop and implement a plan to provide care and services to include education, training, and competencies related to the care of residents diagnosed with Post-traumatic Stress Disorder (PTSD) resulting in one resident (Resident # 22) expressing psychological harm. On 09/25/2023 at 11:50 a.m. during the initial tour of the facility, Resident #22 approached the surveyors (Surveyor C and Surveyor D) and stated he had Post-traumatic Stress Disorder (PTSD), and the facility staff "Did not know how to take care of people diagnosed with PTSD." Resident #22 stated he was upset about it. He stated he "really was diagnosed with PTSD. They (facility staff) act like they don't know how to handle it (PTSD)." Resident #22 stated the staff treated him as if he was "pretending." Resident #22 stated, "this is serious." Resident #22 stated he did not feel understood by the staff. The resident discussed his feelings more in depth with Surveyor D during the survey. On 09/26/2023, the Facility Assessment was	F 838	F838 Facility Assessment 1. Resident #22 still resides in the facility. Resident #22 received psych services 11/1/2023. 2. Current residents in the facility have the potential to be affected. 3. The VPO (vice president of operations) will educate the Administrator on the process for annual review, assessing, updating the facility assessment, and as needed to meet the needs of its resident population, the required resources to provide the care and services the residents to prevent psychological harm care and services to include education, training, and competencies related to the care of residents diagnosed with Post Traumatic Stress Disorder (PTSD) The Administrator will educate the SDC (staff development coordinator) on facility staff education, training, and competencies related to the care of residents diagnosed with Post Traumatic Stress Disorder (PTSD) with triggers. 4. The DON or designee will audit weekly x 4 weeks then monthly x 2 months to verify for new hires and any identified staff not received had education and training on PTSD, behavioral healthcare management and substance was completed with documentation. Results of the review will be presented to	

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F 838	Continued From page 129 reviewed by Surveyor C. Review of the Facility Assessment revealed the Assessment was updated on 08/31/2023 and reviewed with Quality Assurance Assessment/Quality Assurance Performance Improvement (QAA/QAPI) committee on 09/26/2023. On 09/27/2023, an interview was conducted with the Staff Development Coordinator who stated she was responsible for the education of the employees. The Staff Development Coordinator stated she did not provide any training on behavioral health to include Post-traumatic Stress Disorder because she was not aware of the requirement to provide that training to the staff members. She stated she had not been told that particular training was required. When asked if staff members were expected to know how to provide care for the residents accepted in the facility, the Staff Development coordinator stated "yes." Resident #22 reported the facility staff did not know how to take care of him with his diagnosis of PTSD. Resident #22 reported experiencing undue stress related to the staff not taking him seriously. During the end of day debriefing on 09/27/2023, the Facility Administrator, Director of Nursing, and Corporate Nurse Consultant were informed that the Facility Assessment stated the facility accepted residents with behavioral health diagnoses. The Facility Assessment did not address education/training and competencies resources for behavioral health to include Post-traumatic Stress Disorder. On 10/03/2023 during the end of day debriefing,	F 838	the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 838	Continued From page 130 the Facility Administrator, Director of Nursing, Corporate Nurse Consultant, and Regional Vice President of Operations were informed of the findings. No further information was provided.	F 838		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		11/19/23

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F 867	Continued From page 131 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health	F 867		

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F 867	Continued From page 132 outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data	F 867		

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F 867	Continued From page 133 resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to measure the success and track performance in their Quality Assurance and Process Improvement (QAPI) program for their abuse protocols resulting in Immediate Jeopardy involving abuse policy implementation for 2 residents (Residents #12 and #13) on 01/20/2023, and again on 09/27/2023 for 3 residents (Residents #53, #85, and #103) 8 months later. Immediate Jeopardy was found during a standard survey of the facility commencing on 09/25/2023 and conducted through 10/04/2023 when an abatement of the Immediate Jeopardy finding was achieved for the three new residents (Resident #53, #85, and #103), and the facility at large. The findings included; On 01/20/2023, Immediate Jeopardy (IJ) was identified at 3:55 p.m., at which time the facility Administrator and Director of Nursing were made aware. Following verification of the removal of immediacy, the facility abated IJ on 01/26/2023 at 4:07 p.m. The scope and severity was lowered to a level 2, pattern. At that time, the facility failed to implement their abuse policy for 2 residents (Resident #13 and #12) in a survey sample of 9 residents by permitting a known perpetrator of abuse (CNA B)	F 867	F867 QAPI/QAA Improvement Activities 1. Residents #53 and resident #85 no longer reside in the facility. Resident #103 still resides in the facility. A facility reported incident submitted on 9/27/2023 regarding Resident #103 allegation. 2. Current residents in the facility have the potential to be affected. 3. The VPO (vice present of operations) will educate the Administrator on the Quality Assurance and Process Improvement (QAPI) program for their abuse policy and protocols to implement measures to protect residents from abuse, screen employees, report allegations of abuse, conduct investigations of allegations provide education to staff on abuse and mandated reporting. The SDC or designee will educate the facility staff on the QAPI process, abuse policy and protocols, protecting residents, mandated reporters, reporting allegation of abuse to the Administrator or DON. 4. The VPO or RDCS (regional director of clinical services) with audit QAPI process monthly x 3 months to verify QAPI process followed with plan for adhering to abuse policy and protocol s and other identified areas in QAPI. Results of the review will	

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F 867	Continued From page 134 to work in the facility having direct contact with residents on 1 of 2 nursing units. As part of the facility plan of correction, the QAPI committee was tasked with monitoring, measuring, tracking data, and sustaining compliance performance in their abuse prevention programming. On 09/27/2023, IJ was again invoked by the state survey agency for failure to implement their abuse program. The facility staff failed to implement measures to protect residents from abuse as evidenced by their failure to screen employees, failure to take measures to protect residents from alleged perpetrators, failed to report allegations of abuse, failed to conduct investigations of allegations of abuse, and failed to provide education to staff on abuse and mandated reporting. On 08/10/2023, Resident #53 reported an allegation of sexual abuse by a CNA C, stating that the CNA C, "Covered his face with a washcloth," "flicked his penis back and forth," and "said he was going to shave his pubic hair," causing the resident to yell out for help, which caused CNA C to abruptly stop. Resident #53 reported the allegations to the Speech Therapist (ST) at 7:50 a.m. The therapist then reported the allegations immediately to nursing administration. CNA C was permitted to continue to provide care to Resident #53 as evidenced by being seen at 9:30 a.m. aggressively feeding Resident #53 the wrong diet including excessive amounts of food being fed quickly. The Speech Therapist had to intervene	F 867	be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 867	Continued From page 135 as she felt it was not safe. The facility staff failed to conduct an investigation into the allegations and protect the resident by removing the alleged perpetrator immediately. On 08/10/2023 at approximately mid-day, Resident #103 reported an allegation of abuse on behalf of her roommate, Resident #85. Resident #103 stated the same CNA, (CNA C), had shaved Resident #85's pubic area. On 08/10/2023 at 11:57 a.m., a CNA was heard questioning Resident #85 about why she had been shaved "down there." The facility staff failed to report and failed to conduct an investigation into the allegation of abuse involving Resident #85. The facility staff failed to remove the alleged perpetrator, CNA C, until 5 hours after learning of the allegation(s). Facility staff were unable to verbalize what a mandated reporter is. On 09/27/2023 during a review of employee record reviews, it was noted that the facility currently has 2 sampled employees that are actively working, and the facility is unaware of their criminal background status because a criminal background check was not obtained. The facility staff had failed to take measures to implement their abuse policy to identify, protect, report, and investigate allegations of abuse. The facility staff had also failed to screen employees prior to their employment. The facility staff were required to take immediate action to protect residents from failure by the facility to protect, report, investigate, and screen	F 867		

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F 867	Continued From page 136 employees, thus adhering to a federally mandated abuse protocol. Failure to do this would place all residents at risk for further abuse, which could result in physical, sexual, mental, and/or psychosocial harm. The facility was made aware of all findings and proceeded during the course of survey to abate the immediacy, and IJ on 10/04/2023. No further information was provided after abatement; however, the facility was tasked at the end of the inspection with producing a plan of correction in the survey report issued by the state survey agency. The plan of correction will require QAPI involvement, and correction, to the QAPI failed practice in regard to their abuse program.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		11/19/23

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F 880	Continued From page 137 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. §483.80(e) Linens.	F 880		

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F 880	Continued From page 138 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, interview, clinical record review, and facility documentation, the facility staff failed to 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 for residents using the shower rooms on 2 of 2 units. The findings included: On 09/26/2023 at 2:00 p.m. during the Resident Council meeting, the 6 of 6 residents present stated the shower rooms "are filthy, who wants to shower in those rooms?" Resident #42 stated she would rather have a sponge bathe daily than use the shower rooms, and the other 5 participants agreed. A review of the Resident Council minutes revealed that facility cleanliness has been an ongoing complaint in Resident Council. Observations were made of the shower rooms on 09/26/2023. On 09/27/2023 and 09/29/2023 the shower rooms were not clean and the shower stalls had orange and black stains. The shower chairs had brown stains and the floor was dirty as well. On 09/26/2023 at approximately 3:30 p.m., an interview was conducted with CNA D who was	F 880	F880 Infection Prevention & Control 1. Shower rooms were detailed cleaned and disinfected on both units. 2. Current residents in the facility have the potential to be affected. The director of environmental services observed shower rooms on both units to verify cleaning and was maintained. 3. The Director of Environmental Services educated all housekeepers on the cleaning process and scheduling for both shower rooms. The SDC will educate the facility staff on cleanliness of shower rooms or resident rooms report to the director of environmental Services or housekeeping staff if cleaning required and will be clean/disinfected as scheduled by housekeeping. The CNAs will clean and disinfect shower room between resident showers, prevent infection and transmission of communicable diseases. 4. The Director of Environmental Services or designee will conduct weekly x4, then monthly x2 months to verify both shower rooms are cleaned. Results of the review will	

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561 NORTH AIRPORT DRIVE
HIGHLAND SPRINGS, VA 23075

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F 880	Continued From page 139 asked if she knew what the black and orange stains in the shower stall were. CNA D stated she thought the black stains might be dirt. When asked how often the shower stalls were cleaned, she stated, "Housekeeping cleans the shower rooms, but we use the wipes and wipe down the shower chairs between each resident." The Centers for Disease Control and Prevention (CDC) recognizes in their Emerging Infectious Disease Article Volume 25, Number 11 - November 2019, "Serratia marcescens, which can cause nosocomial outbreaks, and urinary tract and wound infections, is abundant in damp environments. It can be easily found in bathrooms, including shower corners and basins, where it appears as a pink-orange-red discoloration, due to the pigment known as prodigiosin." Article accessed online at: https://wwwnc.cdc.gov/eid/article/25/11/et-2511_article. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 880	be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		11/19/23

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F 883	Continued From page 140 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883		

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F 883	Continued From page 141 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to obtain consent and provide education prior to the administration of the flu vaccine for four residents (Residents #43, #47, #20, and #42) in a survey sample of 5 residents reviewed for immunizations. The findings included: For Residents #43, #47, #20 and #42, the facility staff failed to provide education regarding the risks and benefits of the immunization to be administered and failed to obtain consent prior to administration of the immunization. On 09/26/2023, a clinical record review was conducted of the sampled residents reviewed for immunizations. The Surveyor was not able to view all the details regarding the administration of immunizations. On 09/26/2023 at 4:00 p.m., Surveyor F met with the facility's Infection Preventionist (Employee C). During this meeting, Employee C accessed the clinical record of each of the residents and the following was noted: 1. Resident #43 was administered the influenza immunization on 10/17/2022. Consent for the immunization was not obtained until 10/18/2022, and there was no evidence of any education	F 883	F883 Influenza and Pneumococcal Immunizations 1. Residents #43, #47, #20, and #42 received education of the flu vaccination. 2. Current residents in the facility have the potential to be affected. Audit of current residents who received the flu vaccine by the infection preventionist had education provided. Findings will be corrected. 3. SDC or designee will educate licensed nurses on the process for Flu (influenza) vaccinations, education, consents, accuracy of documentation for consents and administration, offered and administered or declines with education provided and documented in the resident medical record. 4. The infection preventionist or designee will audit weekly x 4 then monthly x 2 to verify flu vaccination offered, consent, declined, education provided with accurate documentation. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis.	

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F 883	Continued From page 142 being provided. 2. Resident #47 was administered the flu vaccine on 10/17/2022. There was no evidence of any education being provided, and consent was not obtained until 10/18/2022. 3. Resident #20 was administered the flu vaccine on 10/18/2022. On 12/08/2022, consent was obtained for the immunization and no education was provided. 4. Resident #42 received the flu vaccine on 12/13/2022 and education was not provided until 07/14/2023. During this review, the above noted concerns were shared with the Infection Preventionist (IP), who confirmed the findings. The IP stated that education and consent for immunizations are to be obtained/provided prior to the administration of any immunizations. A review of the facility policy entitled, "Influenza Vaccination," effective date 05/01/2023, was conducted. It stated under the subtitle, "Procedure: item 1, e, read, "Prior to administering the flu vaccine to patients, complete the following: 1. Educate the patient and/or RP [Responsible Party] using the CDC's Vaccination Information Sheet (VIS). Document education in the electronic medical record. 2. Obtain informed consent and document in the electronic medical record." On 09/26/2023 during an end of day meeting, the Director of Nursing and Corporate staff were made aware of the findings.	F 883	5. Date of compliance: 11/19/2023	

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F 883	Continued From page 143 No further information was provided.	F 883		
F 887 SS=F	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative	F 887		11/19/23

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F 887	Continued From page 144 was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide COVID-19 bivalent vaccines for 5 residents (Residents #43, #47, #1, #20, and #42) and 5 staff in a survey sample of 5 residents and 5 employees reviewed for COVID-19 immunizations. They also failed to provide education and obtain informed consent prior to administration of COVID-19 immunizations, for 4 of 5 Residents (Resident #43, #47, #20, and #42). The findings included: 1. The facility staff failed to offer/provide COVID-19 bivalent immunization, to include education of risks/benefits about COVID-19	F 887	F 887 COVID-19 Vaccination 1. Residents #43, #47, #1, #20 and #42 were offered the bivalent COVID-19 with education on risk/benefits for COVID-19 bivalent immunization consent obtained, offered /declined, administered if meets criteria with documentation in the resident medical record. The infection preventionist will schedule staff COVID-bivalent vaccination clinics with education risks/benefits, consents obtained or declined, if accepts administered if meets criteria. 2. Current residents in the facility have the potential to be affected. Audit of current residents by the infection	

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F 887	Continued From page 145 immunization, for Residents #43, #47, #1, #20, and #42. On 09/26/2023, a clinical record review was conducted of the sampled residents reviewed for immunizations. The Surveyor was not able to view all the details regarding the administration of immunizations. There was no indication that any of the sampled residents had been educated on the benefit of or offered the COVID-19 bivalent immunization. 2. The facility staff failed to offer/provide COVID-19 bivalent immunization information to all 5 sampled employees reviewed. On 09/26/2023, a sample of 5 employees was selected for review of being educated on the benefit of immunization and/or offering of COVID-19 immunizations. For the 5 employees reviewed, the COVID-19 immunization status of 2 employees (LPN E and Employee Q) was not known at the time of survey and there was no evidence they had been provided any education or offer for COVID-19 immunizations. The other 3 employees (RN B, CNA E, and CNA F) had no evidence of having received, offered, or having been educated on the benefit of receiving a COVID-19 bivalent immunization. On 09/26/2023 at 4:00 p.m., Surveyor F met with the facility's Infection Preventionist (Employee C). During this meeting Employee C accessed the clinical record of each of the residents and Surveyor F questioned the COVID-19 bivalent vaccine being offered. The facility's Infection Preventionist said, "I have my resident COVID listing, and I go from there."	F 887	preventionist or designee to verify if the resident□s received education for risk/benefits of COVID-19 bivalent vaccine, offered or declined, consent obtained/administered if meets criteria to receive COVID-19 bivalent with completion of documentation on resident□s medical record. 3. SDC or designee will educate licensed nurses and infection preventionist on the process of reviewing resident immunization records and for new admits identify immunization status for COVID-19 bivalent and other immunizations and document in the resident clinical record on process for COVID19 bivalent vaccination requires education to risk/benefits , offered/declined, if accepted ,consent obtained and administered if meets criteria with documented in the resident medical record and planned scheduled staff COVID-19 vaccination clinics for facility staff will include education to risk/benefits , offered / declined , if accepts administered if meets criteria. The SDC will educate the facility staff on COVID-19 bivalent vaccination includes education to risks/benefits, staff vaccination clinics scheduled with dates posted, staff will be offered /declined and administered if meets criteria with documentation. 4. The infection preventionist or designee will audit weekly x 4 then monthly x 2 to verify residents received COVID-19 bivalent vaccination education to risk/benefits, consent obtained , declined/offered/provided with accurate	

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F 887	Continued From page 146 When asked specifically about the bivalent vaccine, the IP said, "Last year we were going to have one [a clinic] but we had issues and didn't." When asked what kind of issues she was referring to, the IP said, "State [surveyors] came in." The IP also stated, "A lot of them are jumping at the bit for COVID vaccine, since it is on the rise again. I told them we will get a clinic started as soon as possible. I have to find out how to order the vaccine and set all of this up." When asked if anyone had been offered the COVID bivalent vaccine since it has been out for a year now, the IP said, "No, not at this point, that's what we have to work on and will be investigating when [Administrator's name redacted] gets back, how to order, where to order, etc." On 09/26/2023 at approximately 5:00 p.m., a review of the facility policy entitled, "COVID-19 Vaccinations," effective date 05/01/2023, was conducted. It stated under the subtitle, "Procedure," item 1, "CDC [Centers for Disease Control and Prevention] recommends that everyone stay up to date with COVID-19 vaccination. b. Recommendations: Individuals who have received one or more doses of a monovalent COVID-19 vaccine: A single dose of a bivalent mRNA vaccine, at least 2 months after any monovalent COVID-19 vaccine." The above policy also stated: "2. Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: a. Provide the Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers" to patient and/or RP and educate regarding benefits and potential side effects. 3. Obtain consent from the patient or responsible party and fill out the consent form."	F 887	documentation in resident□s clinical record and verify staff COVID-19 vaccination clinics scheduled with education and documentation completed for staff COVID-19 vaccination. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 887	Continued From page 147 The Centers for Disease Control and Prevention (CDC) document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States," updated May 12, 2023, page 2, "Recommendations for the use of COVID-19 vaccines," read, "COVID-19 vaccination is recommended for everyone ages 6 months and older in the United States for the prevention of COVID-19" and "CDC recommends that people ages 6 months and older receive at least 1 bivalent mRNA COVID-19 vaccine." On 09/26/2023 during an end of day meeting, the facility's Director of Nursing and Corporate staff were made aware of the findings. No further information was provided. 3. The facility staff failed to provide education and obtain informed consent prior to the administering COVID-19 vaccines. On 09/26/2023, a clinical record review was conducted of the sampled residents reviewed for immunizations. The Surveyor was not able to view all the details regarding the administration of immunizations. On 09/26/2023 at 4:00 p.m., Surveyor F met with the facility's Infection Preventionist (Employee C). During this meeting, Employee C accessed the clinical record of each of the residents and the following was noted: 1. Resident #43 was administered a Pfizer COVID monovalent booster on 12/17/2021. Consent for the immunization was not obtained	F 887		

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F 887	Continued From page 148 until 04/06/2022, and there was no evidence of any education being provided. 2. Resident #47 was administered the Pfizer monovalent COVID booster vaccine dose on 12/17/2021. There was no evidence of any education being provided, and consent was not obtained until 04/06/2022. 3. Resident #20 was administered a Pfizer monovalent booster dose of the COVID vaccine on 12/17/2021. On 04/06/2022, consent was obtained for the immunization and no education was provided. 4. Resident #42 received the Pfizer monovalent COVID booster vaccine on 12/17/2021. Education was not provided, and consent was not obtained until 04/05/2022. During this review, the above noted concerns were shared with the Infection Preventionist (IP), who confirmed the findings. The IP stated that education and consent for immunizations are to be obtained/provided prior to the administration of any immunizations. The facility policy entitled, "COVID-19 Vaccinations," effective date 05/01/2023, was reviewed. It stated under the subtitle, "Procedure," item 1, "CDC [Centers for Disease Control and Prevention] recommends that everyone stay up to date with COVID-19 vaccination. b. Recommendations: Individuals who have received one or more doses of a monovalent COVID-19 vaccine: A single dose of a bivalent mRNA vaccine, at least 2 months after any monovalent COVID-19 vaccine."	F 887		

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F 887	Continued From page 149 The above policy also stated, "2. Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: a. Provide the Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers" to patient and/or RP and educate regarding benefits and potential side effects. 3. Obtain consent from the patient or responsible party and fill out the consent form." On 09/26/2023 during an end of day meeting, the facility's Director of Nursing and Corporate staff were made aware of the findings. No further information was provided.	F 887		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to maintain an effective pest control program so that the facility is free of pests involving 2 of 2 units in the facility. The findings included: For 2 of 2 units in the facility, roaches and/or bedbugs have been reported. On 09/29/2023 at approximately 1:15 p.m., Surveyor E entered Resident #19's room with CNA D, in the search for Resident #19's dentures which were missing. When the cabinet door and	F 925	F925 Maintains Effective Pest Control Program 1. Resident #19 still resides in the facility and pest control treated the room. The pest control team was notified and exterminated all areas identified on both units. The pest control team did a follow-up visit regarding the bed bugs and rooms #32, #37 and #54, there were no other concerns of bed bugs. 2. Current residents in the facility have the potential to be affected . An audit by the maintenance	11/19/23

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F 925	Continued From page 150 drawer were opened, cockroaches ran out (approximately 5-10 insects) all over the sides and top of the bedside cabinet. A review of the pest control log revealed that on 08/04/2023 rooms #32, #37 and #54 were treated for bed bugs; however, no follow-up treatment was done to ensure any eggs that have hatched were treated for, which is standard practice for bedbug treatment. On 09/28/2023, the resident in Room #8 was complaining of itching and stated he had bed bugs. The facility did treat that room on 09/29/2023. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.	F 925	director was conducted for pest sightings. Any findings were treated by the pest control vendor. 3. The Regional Director of Maintenance educated the Maintenance Director on the process of pest control, review of pest control book, bed bug management and maintenance repairs, with followup to ensure all areas of concerns are resolved. The SDC will educate the facility staff on ensuring all and any pest control services are logged in the Pest Control book and work orders submitted for maintenance repairs. 4. The Maintenance Director or designee will conduct audits weekly x 4 weeks then monthly x 2 months to review pest control book to verify pest sightings were treated. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at	F 949		11/19/23

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	495193		C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 949	Continued From page 151 §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation, the facility staff failed to provide behavioral health training for all staff caring for the residents identified as having behavioral healthcare needs for 5 of 5 nursing staff members (Staff #6, Staff #21, Staff #22, Certified Nursing Assistant [CNA]-H and CNA-K) in the sample. The findings included: 1. For all residents identified as having behavioral healthcare needs, the facility failed to provide training to staff to care for such residents. A review of the facility assessment and "CMS form 672 - Census and Condition Form" revealed that there are 46 residents identified with behavioral healthcare needs. A review of the document entitled "Facility Assessment," the facility is equipped to care for residents with behavioral healthcare needs, PTSD (Post-traumatic Stress Disorder), and substance abuse issues. On 09/25/2023 at approximately 1:00 p.m., an interview was conducted with Resident #22 who stated the facility, "Does not know how to deal with us. I have PTSD and they don't know how to talk to me." When asked to elaborate, he stated the facility staff are loud and rude and that "triggers" him to become "aggressive." When asked if he has told anyone about this, he stated he has spoken to the DON and the Administrator about it, but nothing is done. He also stated he had a substance abuse problem prior to coming	F 949	F949 Behavioral Health Training 1. SDC initiated education and training for all facility staff on behavioral healthcare and PTSD (Post traumatic stress disorder) with triggers on 9/27/2023 including identified staff. 2. Current residents in the facility have the potential to be affected. 3. The SDC or designee will educate and training for all facility staff on behavioral healthcare needs and PTSD and triggers, preventing behaviors and/or emotional harm associated with triggering events from past or current trauma. Management, monitoring, preventing behaviors and avoiding triggers that may cause risk for or actual emotional harm for residents with behavioral healthcare needs and residents with substance abuse. Identified residents will have care planned with problem and triggers. 4. The DON or designee will audit weekly x 4 weeks then monthly x 2 months to verify for new hires and any identified staff not received had education and training on PTSD, behavioral healthcare management and substance was completed with documentation. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee	

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F 949	Continued From page 152 to the facility and that the facility staff "use that information against me." When asked what he meant by that, he stated the facility staff "downplay" his pain because he had a substance abuse issue prior to coming to the facility. He stated the staff have labeled him as "drug seeking." On 09/26/2023 at approximately 3:00 p.m., an interview was conducted with Resident #103 who stated she had a substance abuse problem that she was addressing with the methadone clinic. She stated she also had a diagnosis of PTSD due to past trauma. She indicated the staff at the facility did not understand how to care for her. She stated, "They don't know how to talk to me. They don't understand what triggers me and how to handle folks like me." She stated they say she is a "drug seeker." She stated she had a PRN morphine order that she sometimes only took 1 time a day. She said, "If I was drug seeking, I would be asking for it every 4 hours." On 09/28/2023 at 11:00 a.m., an interview was conducted with the Staff Development Coordinator who was asked about training for PTSD. She stated, "They don't tell me to train on that subject." When asked if she trained on trauma-informed care, she stated she did not. When asked if she trained on behavioral healthcare needs related to substance abuse, she stated she did not. When asked does your staff care for residents in this facility with any or all those issues, and she stated they do. On 09/28/2023 at approximately 3:00 p.m., an interview was conducted with the Administrator who was asked if the facility accepts residents with PTSD, substance abuse, or other behavioral	F 949	determines the problem no longer exist and sustained the review will be conducted on a random basis. 5. Date of compliance: 11/19/2023	

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F 949	Continued From page 153 healthcare issues, and she stated they did. When asked if she expected the staff to be equipped with the training to care for those residents, she stated she did. When asked if she was aware that the Staff Development Coordinator was not conducting training on those areas, she stated that she was not. On 10/04/2023 during the end of day debriefing, the Administrator was made aware of the concerns. No further information was provided. 2. The facility failed to provide behavioral health education/training and competencies to include trauma and Post-traumatic Stress Disorder (PTSD) for its staff members. On 09/25/2023 at 11:50 a.m. during the initial tour of the facility, Resident #22 approached the surveyors and stated he had PTSD and the facility staff, "Did not know how to take care of people diagnosed with PTSD." Resident #22 stated he was upset about it. He stated he "really was diagnosed with PTSD. They (facility staff) act like they don't know how to handle it (PTSD)." Resident #22 also stated the staff treated him as if he was "pretending." Resident #22 stated "this is serious." The resident stated he did not feel understood by the staff. On 09/26/2023 at 9:05 a.m., an interview was conducted with Licensed Practical Nurse B (LPN B) who stated there were residents in the facility who had diagnoses of PTSD and other behavioral health conditions. LPN-B stated she had not received specialized training on caring for	F 949		

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F 949	Continued From page 154 residents with trauma/PTSD. On 09/27/2023 at 12:55 p.m., an interview was conducted with Certified Nursing Assistant who stated she had not received any special training on caring for residents with trauma/PTSD. Review of the Facility Assessment revealed a review date of 08/31/2023. The Facility Assessment, Part 2. Services and Care Offered Based on Resident Needs (on page 1 of 2) Section 2.1 General care and Specific Care or Practices listed the general care area of "Mental health and behavior" and under "Specific Care or Practices" was written, "Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with trauma/PTSD, other psychiatric diagnoses." On 09/27/2023 at 2:15 p.m., an interview was conducted with the Staff Development Coordinator who stated she provided in-service education and training to the facility staff members. The Staff Development Coordinator stated staff members also complete computer-based training on required subjects. She stated she was aware the facility accepted residents for admission who were diagnosed with behavioral health issues to include but not limited to mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, or other behavioral health condition and dementia according to the facility assessment. The Staff Development Coordinator stated the facility assessment was utilized to ensure residents could receive the care and services necessary for	F 949		

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F 949	Continued From page 155 their well-being. The Staff Development Coordinator stated she was not told to include trauma/PTSD in the training topics, but would immediately begin to train on that topic. Review of the 5 sampled employee training records revealed no documentation of training on trauma/PTSD. On 09/27/2023 during the end of day debriefing, the facility Administrator, Director of Nursing, and Corporate Nurse Consultant were informed of the findings of no behavioral health training on trauma/PTSD. On 09/28/2023, the Staff Development Coordinator provided a copy of the training curriculum including topics covered during orientation and training sessions. Review of the curriculum revealed there was no documentation of the topic of trauma/PTSD. During the end of day debriefing on 10/3/2023, the facility Administrator, Director of Nursing, Corporate Nurse Consultant, and Vice President of Operations were informed of the findings. No further information was provided.	F 949		