STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/31/23 through 11/2/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/31/23 through 11/2/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. One complaint was investigated during this survey (VA00059056, substantiated with no deficient practice.) The census in this 120 certified bed facility was 107. The survey sample consisted of 29 current residents and five closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550	1. The alleged deficient practice has already occurred and may not be retroactively corrected for resident #65. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of the dining rooms was conducted during lunch service to ensure there were no other residents provided eating assistance by a staff member standing.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11-28-23

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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to protect the dignity of 1 of 34 residents in the survey sample; Resident #65. The findings include: For Resident #65, the facility staff failed to provide eating assistance in a dignified manner.	F 550	3. DON/Designee provided education to nursing staff regarding providing staff assistance during meals in a dignified manner. 4. DON/Designee will perform audits of the dining room during randomly selected meal service times to ensure staff are providing staff assistance in a dignified manner twice a week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of Compliance: 12/15/2023.	

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F 550	Continued From page 2 On the 9/15/23 quarterly MDS (Minimum Data Set) Resident #65 was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance with eating. On 10/31/23 at 1:10 PM an observation was made of Resident #65. She was up in her recliner geri-chair in the dining room area, being fed by CNA #1 (Certified Nursing Assistant). CNA #1 was standing over the resident to feed her. There were empty chairs nearby where CNA #1 could have sat next to Resident #65 to feed her. On 1/11/23 at 7:50 AM an interview was conducted with CNA #1. When asked how one should be positioned when feeding a resident, she stated, "In front of them." When asked if she should be sitting or standing, she stated, "Sitting." When asked if she was sitting when she was feeding Resident #65, she stated, "No, I was not." When asked why she was standing over the resident, she stated, "I don't know. I guess I thought since she was in her geri-chair she was kinda leaned back a little but I know I should have been sitting." When asked if standing over a resident while feeding them is a dignity concern for the resident, she stated that it was. The facility policy, "Dignity," was reviewed. This policy documented, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem... 5. When assisting with care, residents are supported in exercising their rights. For example, residents are:... e. provided with a dignified dining experience...."	F 550		

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F 550	Continued From page 3 On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Vice President of Operations, and LPN #1 (Licensed Practical Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578	1. Advanced Directives were reviewed with residents #78, #33, and #41. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents was conducted to ensure a review of each resident's advanced directives was completed. 3. Administrator/ Designee provided education to the social services department regarding periodic review of advanced directives. 4. Administrator/ Designee will perform an audit of newly admitted current residents to ensure a review of advanced directives has occurred weekly for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/2023	

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F 578	Continued From page 4	F 578		

requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence periodic review of Advance Directives for three of 34 residents in the survey sample; Residents #78, #33 and #41.

The findings include:

1. For Resident #78, the facility staff failed to evidence that periodic review was completed regarding the resident's Advance Directive wishes.

Resident #78 was admitted to the facility on 4/14/21. A review of the physician's orders revealed an order dated 4/24/23 for "DO NOT RESUSCITATE - DNR", and an order dated 5/30/23 for hospice services. In addition, review of the clinical record revealed an "Advance Medical Directive" form dated 11/16/2020.

Further review of the clinical record failed to

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F 578	Continued From page 5 reveal any evidence that the resident and/or resident representative was provided opportunity to review and make changes to the Advance Directive document, formulate a Living Will, or formulate / change other decisions such as organ donation, wishes for any life sustaining treatments, or whether or not to hospitalize if the resident experienced an acute medical condition. On 11/1/23 at 2:01 PM, an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services, and OSM #4 the Social Services Assistant. They stated that during quarterly care plan meetings they do ask residents or family about the resident's code status, whether or not to hospitalize the resident if needed, and if they have any questions, but they don't ask about formulating or changing Living Will or Power of Attorney documents, and other wishes the resident may have such as organ donation or life sustaining treatments. The facility policy, "Advance Directives" documented, "18. The Interdisciplinary Team will periodically [missing word] with the resident his or her advance directives to ensure that such directives are still the wishes of the resident." On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Vice President of Operations, and LPN #1 (Licensed Practical Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #33 (R33), the facility staff failed	F 578		

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F 578	Continued From page 6 to conduct a periodic review of the resident's advance directives. R33 was admitted to the facility on 7/11/14. A review of R33's clinical record revealed documents for a general power of attorney dated 3/30/12 and an advance directive for health care dated 3/26/14. Further review of R33's clinical record failed to reveal evidence that a periodic review of all aspects of advance directives was conducted with R33 or the resident's representative (only the resident's code status was reviewed). On 11/1/23 at 2:01 PM, an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services, and OSM #4 the Social Services Assistant. They stated that during quarterly care plan meetings they do ask residents or family about the resident's code status, whether or not to hospitalize the resident if needed, and if they have any questions. However, they don't ask about formulating or changing Living Will or Power of Attorney documents, and other wishes the resident may have such as organ donation or life sustaining treatments. On 11/1/23 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. 3. For Resident #41, the facility staff failed to periodically review the resident's advance directives. On the most recent MDS (minimum data set)	F 578		

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F 578	Continued From page 7 assessment, an annual assessment, with an assessment reference date of 9/6/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated 6/1/2017 documented, "DNR (do not resuscitate)." Review of the clinical record failed to evidence documents related to advanced directives and documentation of any review of the resident's wishes for an advanced directive. On 11/1/2023 at 2:01 p.m., an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services, and OSM #4 the Social Services Assistant. They stated that during quarterly care plan meetings they do ask residents or family about the resident's code status, whether or not to hospitalize the resident if needed, and if they have any questions. However, they don't ask about formulating or changing Living Will or Power of Attorney documents, and other wishes the resident may have such as organ donation or life sustaining treatments. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM #4, the regional director of operations, and LPN (licensed practical nurse) #1, the assistant director of nursing, were made aware of the above concern on 11/1/2023 at 4:32 p.m. No further information was provided prior to ext.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		

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F 580	Continued From page 8 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580	1. The provider was notified of the unavailable medication for resident #35. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents receiving diabetic related medications was conducted to identify those that were unavailable over the last two weeks to ensure the provider was notified. 3. DON/Designee provided education to licensed nursing staff regarding notification of the provider for unavailable medication. 4. DON/Designee will perform an audit of current residents receiving diabetic related medications to identify those that were unavailable to ensure the provider was notified twice per week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of Compliance: 12/15/2023.	

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F 580	Continued From page 9 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the physician of a possible need to alter treatment for one of 34 residents in the survey sample, Resident #35. The findings include: For Resident #35 (R35), the facility staff failed to notify the physician when the resident's medication Jardiance (1) was not available for administration on 10/9/23 and 10/10/23. A review of R35's clinical record revealed a physician's order dated 3/13/23 for Jardiance 25 mg (milligrams) by mouth one time a day for type two diabetes mellitus. A review of R35's October 2023 MAR (medication administration record) revealed the same physician's order for Jardiance. On 10/9/23 and 10/10/23, the MAR documented the code, "9= Other/ See Progress Notes." Nurses' notes dated 10/9/23 and 10/10/23 documented the medication Jardiance was not administered and was on order. Further review of R35's clinical record failed to reveal the resident's physician was notified and made aware	F 580		

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F 580	Continued From page 10 the medication was not available for administration. On 11/1/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the physician should be notified if a medication is not available for administration to see if the physician wants to adjust for an alternative medication that may be available, and so the resident can be monitored for any adverse effects from not receiving the medication. On 11/1/23 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Reference: (1) Jardiance is used to lower blood sugar levels for people with diabetes mellitus. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a614043.html	F 580		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F 645	1. PASSAR was completed for resident #24. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents was conducted to ensure each resident has a PASSAR completed. 3. Administrator/ Designee provided education to the admissions and social services departments regarding the need for a complete PASSAR for each resident.	

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F 645	Continued From page 11 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified,	F 645	4. Administrator/Designee will perform an audit of current residents newly admitted to ensure each resident has a PASSAR completed weekly for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/2023	

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F 645	Continued From page 12 before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed for one of 34 residents in the survey sample; Resident #24. The findings include: For Resident #45, the facility failed to complete a PASARR. Resident #24 was admitted to the facility on 2/23/22. A review of the clinical record revealed a "Medicaid Funded Long-Term Care Services Authorization Form" document dated 2/26/20. This document included "3. Pre-Admission Screening Information (to be completed only by Level I, Level II or ALF screeners)....Level I/ALF Screening Identification? YES...Level II Assessment Determination? NO...." The document did not contain any of the questions and responses of the State PASARR screening	F 645		

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F 645	Continued From page 13 form. On 11/1/23 at 2:30 PM, OSM #3 (Other Staff Member) the Director of Social Services, was asked about this document. She stated that it was all the facility had and that it did not meet the requirement of a PASARR. The facility policy Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy" was reviewed. This policy documented, ".... Level 1 Screening: a. If a Level 1 Screening has not been completed prior to admission and the resident is already Medicaid member OR financially eligible by way of application as verified by the ePAS system, the Social Worker, Admissions Coordinator, or designee will request that the referral provider and/or Community Screening Team complete the screen prior to admission; b. If the resident is not Medicaid or Medicaid eligible by way of application, the nursing facility will be responsible for completion of the Level 1 screening..." On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Vice President of Operations, and LPN #1 (Licensed Practical Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 14 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	1. A medication error was completed for resident #94. The alleged deficient practice has already occurred and may not be retroactively corrected for resident #11. The alleged deficient practice has already occurred and may not be retroactively corrected for resident #29. The oxygen concentrators for residents #97 and #46 were adjusted and verified at eye level to the prescribed rate. Resident #106 has discharged from the facility. The provider was notified of the unavailable medication for resident # 35. A care plan focus related to PTSD was added to the care plan for resident #23. The alleged deficient practice has already occurred and may not be retroactively corrected for resident #46.	

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F 656	Continued From page 15 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for eight of 34 residents in the survey sample; Residents #94, #11, #29, #97, #106, #23, #35, and #46. The findings include: 1. For Resident #94, the facility staff failed to follow the comprehensive care plan for the administration of diabetic related medications as ordered. A review of the comprehensive care plan revealed one dated 9/2/23 for "The resident has Diabetes Mellitus." This care plan included the intervention dated 9/2/23 for "Diabetes medication as ordered by doctor..." A review of the clinical record revealed the following orders: 1. An order dated 7/27/23 for Humalog (1) 10 units twice daily, before breakfast and lunch. 2. An order dated 7/7/23 for Humalog, dose per sliding scale, before breakfast and lunch. (Resident #94's glucose level was 217. The sliding scale dose order included, 200 - 249 = 2 units).	F 656	2. All residents of the facility have the potential to be affected by the alleged deficient practice. A medication administration competency was completed with LPN #5. An audit of current residents was completed to ensure the bathing and shower task is available for the nursing staff to complete documentation. An audit of current residents with an order for fluid restriction was conducted to ensure the order was entered appropriately to allow for documentation of intake. An audit of the administration records of current residents receiving dialysis was conducted for the past two weeks to ensure the bruit and thrill were monitored each shift;the provider was notified of identified variances. An audit of current residents receiving dialysis was conducted to ensure communication with the dialysis center occurred each scheduled dialysis day; the provider was notified of identified variances. An audit of current residents ordered supplemental oxygen was performed to ensure the tank/concentrator was set to deliver the prescribed rate. An audit of current residents with side rails was conducted to ensure review of the risks and benefits occurred, as well as informed consent was obtained.	

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F 656	Continued From page 16 On 11/01/23 at 8:20 AM, the Medication Administration task was conducted with LPN #5 (Licensed Practical Nurse) for Resident #94. The following was observed: 1. Humalog 10 units, scheduled, was administered after the resident had breakfast. 2. Humalog 2 units based on sliding scale, was administered after the resident had breakfast. On 11/1/23 at 2:49 PM an interview was conducted with LPN #5. When asked if Resident #94's insulin was administered in accordance with the physician's order of before breakfast, she stated it was not, because it was administered after breakfast. She stated that the resident won't take it before breakfast because he is afraid his glucose will drop. When asked if the doctor was aware of this, she stated that the doctor was aware but that this was still the order, so it should have been given before breakfast. When asked if the care plan was followed if it documented to administer diabetic medication as ordered, she stated that it was not. When asked what was the purpose of the care plan, she stated it was to make sure all the goals are being followed and the resident's needs are being met. The facility policy "Care Planning - Comprehensive Person-Centered" was reviewed. This policy documented, "2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process..."	F 656	An audit of current residents with weight orders was performed to ensure weights were completed per order; the provider was notified of identified variances. An audit of current residents receiving diabetic related medications was conducted to identify those that were unavailable over the last two weeks to ensure the provider was notified. An audit of current residents with a diagnosis of PTSD was performed to ensure the care plan appropriately addresses the diagnosis. An audit of residents with splinting devices was conducted to ensure each was in place per order. 3. DON/Designee provided education to licensed nursing staff regarding development and implementation of the care plan. 4. DON/Designee will perform a medication administration audit with a randomly selected nurse twice a week for four weeks. DON/Designee will perform an audit of 10% of current residents to ensure bathing/showering was documented as provided in the electronic medical record. DON/Designee will perform an audit of current residents with an order for fluid restriction to ensure documentation reflects monitoring of intake weekly for four weeks. DON/Designee will perform an audit of the administration record of current residents receiving dialysis to ensure the bruit and thrill were monitored each shift weekly for four weeks. DON/Designee will perform	

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F 656	Continued From page 17 On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Vice President of Operations, and LPN #1 the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. References: 1. Humalog is used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html 2. For Resident #11, the facility staff failed to implement the comprehensive care plan for ADL's (activities of daily living). Resident #11 was admitted to the facility on 11/22/21 with diagnoses that included but were not limited to: peripheral vascular disease (PVD), right AKA (above the knee amputation) and diabetes mellitus. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 9/25/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired. A review of the MDS Section G,functional status, revealed the resident was coded as requiring extensive assistance for bed mobility, transfer, dressing and hygiene; total dependence for bathing. A review of the comprehensive care plan dated 2/3/23 revealed, "FOCUS: Resident has an ADL	F 656	an audit of current resident receiving dialysis to ensure communication with the dialysis centered occurred each scheduled dialysis day weekly for four weeks. DON/Designee will conduct an audit of current residents ordered supplemental oxygen to ensure the tank/concentrator is set to deliver oxygen at the prescribed rate twice per week for four weeks. DON/Designee will conduct an audit of current residents with newly implemented side rails to ensure review of risk and benefits, as well as consent was obtained. DON/Designee will perform an audit of 10 % of current residents with weight orders was performed to ensure weights were completed per order weekly for four weeks. DON/Designee will perform an audit of current residents receiving diabetic related medications to identify those that were unavailable and ensure the provider was notified twice a week for four weeks. DON/Designee will perform and audit of newly admitted residents with a diagnosis of PTSD to ensure the care plan appropriately addresses the diagnosis weekly for four weeks. DON/Designee will perform and audit of 10% of current residents ordered a splinting device to ensure placement per order twice a week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/2023.	

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F 656	Continued From page 18 self-care performance deficit related to weakness and right leg amputation. INTERVENTIONS: Provide supervision and cuing as needed with ADLs. Physical assist as needed with ADLs." A review of the ADL document in Resident #11's medical record revealed showers were scheduled for Wednesday and Saturday. Review of the August 2023 record revealed missing documentation on 8/23/23 and 8/26/23. Review of the September 2023 record revealed missing documentation on 9/6/23 and 9/30/23. Review of the October 2023 record revealed missing documentation on 10/4/23, 10/7/23, 10/11/23, 10/18/23, 10/21/23, 10/25/23 and 10/28/23. An interview was conducted on 11/1/23 at approximately 11:00 AM with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is to lay out the care that each resident needs. Asked if the care plan was being implemented if there was no evidence of showers/bathing, LPN #4 stated, "No, it is not." On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM #4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. 3. For Resident #29, the staff failed to implement the comprehensive care plan for dialysis care and fluid restriction. Resident #29 was admitted to the facility on 10/4/23 with diagnoses that included but were not	F 656		

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F 656	Continued From page 19	F 656		

limited to: ESRD (end stage renal disease) and diabetes.

The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 10/10/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G, functional status, revealed the resident was coded as being independent for eating, bed mobility, transfer, walking and locomotion.

A review of the comprehensive care plan dated 10/4/23 revealed, "FOCUS: Resident has ESRD and receives Hemodialysis at dialysis center on Monday-Wednesday-Friday. INTERVENTIONS: Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols."

A review of the physician's orders dated 10/4/23 revealed, "Dialysis at (specify place) on Monday, Wednesday, Friday. Fluid Restriction 1500 ml Daily every shift Record. Shift Intake AND every night shift Record 24-hr Intake. Assess Dialysis Fistula/Graft to Right forearm for Thrill and Bruit Daily and signs and symptoms of infection every shift. Check dialysis port to Right forearm each shift. Keep dressing dry on bath days. Do not remove dressing, this will be done at dialysis. Every shift."

A review of Resident #29's October 2023 MAR (medication administration record) and TAR (treatment administration record) revealed no documentation of assessment of the dialysis fistula/graft for thrill and bruit, and for signs of

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F 656	Continued From page 20 infection, for day shift on 10/5/23, 10/6/23 and 10/27/23. A review of Resident #29's dialysis communication book revealed missing communication forms from the facility to the provider for six of twelve dialysis treatments: 10/11/23, 10/13/23, 10/16/23, 10/18/23, 10/27/23 and 10/30/23. An interview was conducted on 11/1/23 at 10:00 AM with RN (registered nurse) #1. RN #1 stated the purpose is to define the goals and interventions for each resident. She stated if the documentation of fluid restriction, bruit, thrill and dialysis site are missing, the care plan was not implemented. On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. 4. For Resident #97, the staff failed to implement the comprehensive care plan for oxygen therapy. Resident #97 was admitted to the facility on 10/2/23 with a diagnosis of COPD (chronic obstructive pulmonary disease). A review of the comprehensive care plan dated 10/4/23 revealed, "FOCUS: Resident has altered respiratory status/difficulty breathing related to COPD and wheezing. INTERVENTIONS: OXYGEN SETTINGS: Oxygen as ordered."	F 656		

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F 656	Continued From page 21 A review of the physician orders dated 10/22/23 revealed the following: "O2 at 2LPM (liters per minute) via nasal cannula to maintain oxygen at 90% or above. Every shift for Hypoxia." An interview was conducted on 10/31/23 at 1:53 PM with LPN (licensed practical nurse) #3. Asked to look at the oxygen setting for Resident #97, LPN #3 stated, "It is on 2.5 liters. I checked it this morning and it is at the same setting." Asked if care plan is being implemented if the orders are for 2 liters per minute, and the care plan documents oxygen as ordered, LPN #3 stated the care plan is not being implemented. On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. 5. For Resident #106, the staff failed to develop the comprehensive care plan for weights and bedrails. Resident #106 was observed in bed with one quarter bed rails on both sides of the bed on 10/31/23 at 12:00 PM, 11/1/23 at 9:00 AM, and 11/1/23 at 10:45 AM. A review of the comprehensive care plan dated 10/6/23 revealed, "FOCUS: Resident is at risk for alteration in nutritional status related to new admission/facility adjustment, CKD, diuretic use for edema. INTERVENTIONS: Weights per	F 656		

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F 656	Continued From page 22 protocol." A review of the physician orders dated 10/6/23 revealed the following: "Daily Weight x3 (times three days) days, Weekly Weight x4 weeks, then monthly." A review of the weight documentation revealed no evidence of a weight documentation on 10/16/23, 10/23/23 and 10/30/23. An interview was conducted on 11/1/23 at approximately 11:00 AM with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of a care plan is to lay out the care that each resident needs. When asked if weights and bedrails should be on the care plan, LPN #4 stated they usually are. When asked if the care plan is completely developed if it does not include information regarding weights and bedrails, LPN #4 stated it is not. On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. 6. For Resident #35 (R35), the facility staff failed to implement the resident's comprehensive care plan for diabetic medication. R35's comprehensive care plan dated 7/22/21 documented, "(R35) has diabetes mellitus. Interventions: Diabetes medication as ordered by doctor..." A review of R35's clinical record	F 656		

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F 656	Continued From page 23 revealed a physician's order dated 3/13/23 for Jardiance (1) 25 mg (milligrams) by mouth one time a day for type two diabetes mellitus. A review of R35's October 2023 MAR (medication administration record) revealed the same physician's order for Jardiance. On 10/9/23 and 10/10/23, the MAR documented the code, "9= Other/ See Progress Notes." Nurses' notes dated 10/9/23 and 10/10/23 documented the medication Jardiance was not administered and was on order. On 11/1/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is to allow for the most personalized care of each individual resident, and all care plans are available for nurses' review to ensure they are implemented. LPN #4 stated medications should be re-ordered from the pharmacy when there is a five-day supply of the medication left. LPN #4 stated that if a medication is not available for administration, then the nurses should pull the medication from the facility backup medication supply, and if the medication is not in the backup supply, then nurses should update the physician and resident's family. On 11/1/23 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Reference: (1) Jardiance is used to lower blood sugar levels for people with diabetes mellitus. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a614043.html	F 656		

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SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 656	Continued From page 24 7. For Resident #23 (R23), the facility staff failed to develop a comprehensive care plan regarding the resident's PTSD (post-traumatic stress disorder). R23 was admitted to the facility on 1/16/22 with a diagnosis of PTSD. R23's comprehensive care plan dated 11/7/21 documented the resident uses psychotropic medication related to PTSD, but failed to document any further information such as goals and interventions for the resident's PTSD. A psychiatry note dated 10/16/23 documented, "Additional supportive psychotherapy interventions: Insight-oriented Psychotherapy, 1:1 Supportive therapy, Relaxation Techniques, Active Problem Solving, Positive Feedback, Encouragement, Sleep Hygiene..." On 11/1/23 at 9:53 a.m., an interview was conducted with OSM (other staff member) #4 (the social services assistant). OSM #4 stated the purpose of the care plan is so that staff knows about the resident and everything that is going on. OSM #4 stated R23 does not display signs and symptoms of PTSD, but she felt the care plan should explain more regarding the resident's PTSD, such as the cause of the PTSD and potential signs and symptoms such as nightmares and flashbacks. OSM #4 stated R23's care plan should include goals and interventions for the resident's PTSD, and this should be based on each specific individual. On 11/1/23 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 656		

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F 656	Continued From page 25	F 656		

8.a. For Resident #46, the facility staff failed to implement the comprehensive care plan for administering oxygen per the physician orders.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/2/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions.

The comprehensive care plan dated 9/29/2022 documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) hx (history) of malignant neoplasm of lung, hx of smoking. Requires HOB (head of bed) elevated due to SOB when lying flat...Oxygen as ordered."

The physician order dated 2/15/2022 documented, "Oxygen therapy at 1 L/min (liters per minute) via nasal cannula every shift for SOB (shortness of breath)."

Observation was made of R46 on 10/31/2023 at approximately 1:30 p.m. R46 was lying in bed with a nasal cannula in place with oxygen being delivered. The oxygen concentrator flowmeter was numbered two to ten, with two being the first number on the bottom and ten being the top number on the flowmeter. There were no lines below the number two to indicate any level of oxygen below two. The ball was set at the bottom of the flowmeter. The top of the ball was touching the line for two liters per minute.

A second observation was made of the R46 on

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F 656	Continued From page 26 11/1/2023 at 8:28 a.m. The oxygen concentrator was set with the top of the ball touching the line for two liters per minute. The resident had the nasal cannula in her nose. A third observation was made of R46 on 11/1/2023 at 12:00 p.m. with LPN (licensed practical nurse) #5. When asked what the oxygen was set at, LPN #5 stated that it was on one. When asked the locationin of the line indicating one liter per minute, LPN #5 stated, "I guess I screwed up. I thought that it was below two and if I could feel oxygen coming out, then it was at one." LPN #5 was asked how to set the flow rate of the oxygen. She stated the line of the prescribed rate should go through the center of the ball. When asked if the oxygen was set according to the physician order, LPN #5 stated it was not. LPN #5 stated the purpose of the care plan is to make sure the resident's goals, both short and long term, are being followed for them to get the best care. When asked if R46's care plan was being followed for oxygen administration, she stated it was not. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM #4, the regional director of operations, and LPN (licensed practical nurse) #1, the assistant director of nursing, were made aware of the above concern on 11/1/2023 at 4:32 p.m. No further information was provided prior to exit. 8.b. For Resident #46, the facility staff failed to implement the care plan for administering treatments per the physician orders.	F 656		

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F 656	Continued From page 27 The comprehensive care plan dated, 5/16/2023, documented in part, "Focus: The resident has an ADL (activities of daily living) self-performance deficit r/t (related to) Fibromyalgia, prior CVA (stroke) with left hemiparesis and left hand/wrist contracture." The "Interventions" documented in part, "CONTRACTURES: The resident has contractures of the left hand/wrist. Provide skin care to keep clean and prevent skin breakdown." The care plan further documented, "Focus: The resident has potential for skin impairment r/t dermatitis, incontinence, candidiasis (1). Left hemiparesis and decrease in mobility." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness." The physician order dated 5/22/2023 documented, "Ensure rolled up washcloth to inside of left grip at all times, change washcloth daily or as needed if soiled, every shift for contracture, skin protection." Observation was made of R46 on 11/1/2023 at 8:27 a.m. There was no washcloth in her left hand. The resident stated sometimes the staff remembers to put it in there and sometimes they don't. A second observation was made of R46 on 11/1/2023 at 11:54 a.m. No washcloth was noted in the resident's left hand. The resident's hand was warm and moist. An interview was conducted with LPN (licensed practical nurse) #5 on 11/01/23 12:00 p.m. When asked if R46 is to have a washcloth in her left hand, LPN #5 stated another nurse is doing the treatments for the day. When asked how the	F 656		

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F 656	Continued From page 28 aides are informed about what is needed for R46, LPN #5 stated most of the aides know about it. LPN #5 was asked why the resident had the washcloth in her hand. LPN #5 stated, "It's because she has a contracture and gets yeast infections in that hand." LPN #5 stated the purpose of the care plan is to make sure the resident's goal, both short and long term, are being followed for them to get the best care. When asked if the resident's care plan for the washcloth in the left hand was being followed, she stated it was not. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM #4, the regional director of operations, and LPN (licensed practical nurse) #1, the assistant director of nursing, were made aware of the above concern on 11/1/2023 at 4:32 p.m. No further information was provided prior to exit.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice for one of 34 residents in the survey sample; Resident #94.	F 658	1. A medication error was completed for resident #94. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. A medication administration competency was completed with LPN #5. 3. DON/Designee provided education to licensed nursing staff regarding the 5 rights of medication. 4. DON/Designee will perform a medication administration audit with a randomly selected nurse twice a week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of Compliance: 12/15/2023	

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F 658	Continued From page 29 The findings include: For Resident #94, the facility staff failed to administer Humalog as ordered by the physician. A review of the clinical record revealed the following orders: 1. An order dated 7/27/23 for Humalog (1) 10 units twice daily, before breakfast and lunch. 2. An order dated 7/7/23 for Humalog, dose per sliding scale, before breakfast and lunch. (Resident #94's glucose level was 217. The sliding scale dose order included, 200 - 249 = 2 units). On 11/01/23 at 8:20 AM, the Medication Administration task was conducted with LPN #5 (Licensed Practical Nurse) for Resident #94. The following was observed: 1. Humalog 10 units, scheduled, was administered after the resident had breakfast. 2. Humalog 2 units based on sliding scale, was administered after the resident had breakfast. When asked if Resident #94's insulin was administered in accordance with the physician's order of before breakfast, she stated it was not, because it was administered after breakfast. She stated that the resident won't take it before breakfast because he is afraid his glucose will drop. When asked if the doctor was aware of this, she stated that the doctor was aware but that this was still the order, so it should have been given before breakfast. A review of the comprehensive care plan dated 9/2/23 revealed: "The resident has Diabetes	F 658		

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F 658	Continued From page 30 Mellitus." This care plan included the intervention dated 9/2/23 for "Diabetes medication as ordered by doctor..." The facility policy, "General Guidelines for Medication Administration," was reviewed. This policy documented, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer." On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Vice President of Operations, and LPN #1 the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. References: 1. Humalog is used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688	1. The alleged deficient practice has already occurred and may not be retroactively corrected for resident #46. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of residents with splinting devices was conducted to ensure each was in place per order.	

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F 688	Continued From page 31 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement interventions for the prevention of a decrease in range of motion for one of 34 residents in the survey sample, Resident #46. The findings include: For Resident #46 (R46), the facility staff failed to place a washcloth in the resident's left hand per the physician orders. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/2/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. In Section G, Functional Status, the resident was coded as having functional limitations in range of motion with impairment on one side of upper and lower extremities. The physician order dated 5/22/2023 documented, "Ensure rolled up washcloth to inside of left grip at all times, change washcloth daily or as needed if soiled, every shift for	F 688	3. DON/Designee provided education to licensed nursing staff regarding implementation of intervention to prevent a decrease in range of motion per provider's order. 4. DON/Designee will perform and audit of 10% of current residents ordered a splinting device to ensure placement per order twice a week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of Compliance: 12/15/2023.	

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F 688	Continued From page 32 contracture, skin protection." Observation was made of R46 on 11/1/2023 at 8:27 a.m. There was no washcloth in her left hand. The resident stated sometimes the staff remembers to put it in there and sometimes they don't. A second observation was made of R46 on 11/1/2023 at 11:54 a.m., no washcloth was noted in the resident's left hand. The resident's hand was warm and moist. An interview was conducted with CNA (certified nursing assistant) #4 on 11/1/2023 at 11:56 a.m. When asked if there was anything special that needed to be done for R46 related to her positioning, CNA #4 stated the resident likes a pillow under her left arm. CNA #4 was asked if the resident required anything special for her left hand. CNA #4 stated she remembered the resident had a brace at one time, and that she had a washcloth in that hand the other day. When asked how she finds out what a resident may need specific to that resident, CNA #4 stated: I just go on observation of how her hand is." An interview was conducted with LPN (licensed practical nurse) #5 on 11/01/23 12:00 p.m. When asked if R46 is to have a washcloth in her left hand, LPN #5 stated another nurse was doing the treatments for the day and had already signed it off. When asked how the aides are informed about what is needed for R46, LPN #5 stated most of the aides know about it. LPN #5 stated the purpose of the washcloth in the left hand is due to the resident's contracture, and the resident gets yeast infections in that hand.	F 688		

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F 688	Continued From page 33 The comprehensive care plan dated, 5/16/2023, documented in part, "Focus: The resident has an ADL (activities of daily living) self-performance deficit r/t (related to) Fibromyalgia, prior CVA (stroke) with left hemiparesis and left hand/wrist contracture...CONTRACTURES: The resident has contractures of the left hand/wrist. Provide skin care to keep clean and prevent skin breakdown..Focus: The resident has potential for skin impairment r/t dermatitis, incontinence, candidiasis (1). Left hemiparesis and decrease in mobility...Administer treatments as ordered and monitor for effectiveness." The facility policy, "Resident Mobility and Range of Motion," documented in part, "POLICY: 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable...6. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. 7. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM #4, the regional director of operations, and LPN	F 688		

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F 688	Continued From page 34 (licensed practical nurse) #1, the assistant director of nursing, were made aware of the above concern on 11/1/2023 at 4:32 p.m. No further information was provided prior to exit. References: (1) Candidiasis is a fungal infection caused by a yeast (a type of fungus) called Candida. This information was obtained from the following website: https://www.cdc.gov/fungal/diseases/candidiasis/.	F 688		
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, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory services per the physician orders for two of 34 residents in the survey sample, Residents #46 and #97. The findings include: 1. For Resident #46 (R46), the facility staff failed to have the correct oxygen concentrator to provide oxygen at the physician prescribed rate.	F 695	1. The oxygen concentrator for residents #46 and #97 were adjusted and verified at eye level to the prescribed rate. 2. All residents of the facility have the potential be affected by the alleged deficient practice. An audit of current residents ordered supplemental oxygen was performed to ensure the tank/concentrator was set to deliver the prescribed rate. 3. DON/Designee provided education to licensed nursing staff regarding providing oxygen at the prescribed rate. 4. DON/Designee will conduct an audit of current residents ordered supplemental oxygen to ensure the tank/concentrator is set to deliver oxygen at the prescribed rate twice per week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/2023.	

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F 695	Continued From page 35 On the most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 8/2/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. Observation was made of R46 on 10/31/2023 at approximately 1:30 p.m. R46 was lying in bed with a nasal cannula in place with oxygen being delivered. The oxygen concentrator flowmeter was numbered two to ten, with two being the first number on the bottom and ten being the top number on the flowmeter. There were no lines below the number two to indicate any level of oxygen below two. The ball was set at the bottom of the flowmeter. The top of the ball was touching the line for two liters per minute. The physician order dated 2/15/2022 documented, "Oxygen therapy at 1 L/min (liters per minute) via nasal cannula every shift for SOB (shortness of breath)." A second observation was made of the R46 on 11/1/2023 at 8:28 a.m. The oxygen concentrator was set with the top of the ball touching the line for two liters per minute. The resident had the nasal cannula in her nose. A third observation was made of R46 on 11/1/2023 at 12:00 p.m. with LPN (licensed practical nurse) #5. When asked what the oxygen was set at, LPN #5 stated that it was on one. When asked the locationin of the line indicating one liter per minute, LPN #5 stated, "I guess I screwed up. I thought that it was below two, and if	F 695		

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F 695	Continued From page 36	F 695		

I could feel oxygen coming out, then it was at one." LPN #5 was asked how to set the flow rate of the oxygen. She stated the line of the prescribed rate should go through the center of the ball. When asked if the oxygen was set according to the physician order, LPN #5 stated it was not.

The comprehensive care plan dated 9/29/2022 documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) hx (history) of malignant neoplasm of lung, hx of smoking. Requires HOB (head of bed) elevated due to SOB when lying flat...Oxygen as ordered."

The facility policy, "Oxygen Administration," documented in part, "POLICY: The purpose of this procedure is to provide guidelines for safe oxygen administration...1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration...5.Turn on the oxygen at the number of liters / minutes as ordered by the physician/practitioner."

The manufacturer's booklet for the Invacare Platinum 10 L (liter) Oxygen Concentrator documented in part, "1. Turn the flowrate knob to the setting prescribed by your physician or therapist. To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM #4,

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F 695	Continued From page 37 the regional director of operations, and LPN (licensed practical nurse) #1, the assistant director of nursing, were made aware of the above concern on 11/1/2023 at 4:32 p.m. No further information was provided prior to ext. 2. For Resident #97, the facility staff failed to provide respiratory therapy as ordered. Resident #97 was observed with oxygen setting at 2.5 lnc (liters nasal cannula) on 10/31/23 at 12:00 PM and 10/31/23 at 1:53 PM. Resident #97 was admitted to the facility on 10/2/23 with diagnosis that included atrial fibrillation, multiple fractures and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) assessment, a Medicare 5-day admission assessment with an ARD (assessment reference date) of 10/25/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired. Section G, functional, status coded the resident as being dependent for bed mobility, transfer, dressing and hygiene; total dependence for bathing. A review of the comprehensive care plan dated 10/4/23, revealed, "FOCUS: Resident has altered respiratory status/difficulty breathing related to COPD and wheezing. INTERVENTIONS: OXYGEN SETTINGS: Oxygen as ordered." A review of the physician orders dated 10/22/23 revealed, "O2 at 2LPM via nasal cannula to maintain oxygen at 90% or above. every shift for Hypoxia."	F 695		

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F 695	Continued From page 38 An interview was conducted on 10/31/23 at 1:53 PM with LPN (licensed practical nurse) #3. When asked to look at the oxygen setting for Resident #97, LPN #3 stated it was on 2 liters. She stated: "I checked it this morning and it is at the same setting." LPN #3 stated the middle of the flowmeter ball should be on the line for the correct number of liters. On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. A review of the facility's "Oxygen Administration" policy revealed: "The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." No further information was provided prior to exit.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 698	1. The alleged deficient practice has already occurred and may not be retroactively corrected for resident #29. The fluid restriction is not longer appropriate for resident #29 and has been discontinued. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents with an order for fluid restriction was conducted to ensure the order was entered appropriately to allow for documentation of intake.	

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F 698	Continued From page 39 clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 34 residents in the survey sample, Resident #29. The findings include: For Resident #29, the facility failed to monitor for fluid restriction and intake, failed to assess for bruit and thrill at the dialysis access site, and failed to maintain a complete communication system with the dialysis center. Resident #29 was admitted to the facility on 10/4/23 with diagnosis that included but were not limited to: ESRD (end stage renal disease) and diabetes. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 10/10/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being independent for eating, bed mobility, transfer, walking and locomotion. A review of the comprehensive care plan dated 10/4/23, which revealed, "FOCUS: Resident has ESRD and receives Hemodialysis at dialysis center on Monday-Wednesday-Friday. INTERVENTIONS: Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols." A review of the physician's orders dated 10/4/23, revealed, "Dialysis at (specify place) on Monday,	F 698	An audit of the administration records of current residents receiving dialysis was conducted for the past two weeks to ensure the bruit and thrill were monitored each shift; the provider was notified of identified variances. An audit of current residents receiving dialysis was conducted to ensure communication with the dialysis center occurred each scheduled dialysis day; the provider was notified of identified variances. 3. DON/Designee will education licensed nursing staff regarding monitoring fluid restrictions and bruit and thrill each shift, as well as utilization of dialysis communication books. 4. DON/Designee will perform an audit of current residents with an order for fluid restriction to ensure documentation reflects monitoring of intake weekly for four weeks. DON/Designee will perform an audit of the administration record of current residents receiving dialysis to ensure the bruit and thrill were monitored each shift weekly for four weeks. DON/Designee will perform an audit of current resident receiving dialysis to ensure communication with the dialysis centered occurred each scheduled dialysis day weekly for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/2023.	

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F 698	Continued From page 40 Wednesday, Friday. Fluid Restriction 1500 ml Daily every shift Record shift Intake and every night shift Record 24-hr Intake. Assess Dialysis Fistula/Graft to Right forearm for Thrill and Bruit Daily and signs and symptoms of infection every shift. Check dialysis port to Right forearm each shift. Keep dressing dry on bath days. Do not remove dressing, this will be done at dialysis. every shift." A review of Resident #29's October 2023 MAR (medication administration record) and TAR (treatment administration record) revealed no documentation of assessment of the dialysis fistula/graft for thrill and bruit, and for signs of infection, for day shift on 10/5/23, 10/6/23 and 10/27/23. A review of Resident #29's dialysis communication book revealed missing communication forms from the facility to the provider for six of twelve dialysis treatments: 10/11/23, 10/13/23, 10/16/23, 10/18/23, 10/27/23 and 10/30/23. A review of Resident #29's October 2023 MAR (medication administration record) and TAR (treatment administration record) revealed no evidence of fluid restriction being monitored or documented. An interview was conducted on 11/1/23 at 10:00 AM with RN (registered nurse) #1. When asked where bruit, thrill and dialysis site assessments are documented, RN #1 stated it would be documented on the TAR. When asked where fluid restriction and intakes are documented, she stated it would be documented on the TAR. She stated if there is no documentation, then the services were not provided.	F 698		

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F 698	Continued From page 41 On 11/1/23 at approximately 11:00 AM, LPN (licensed practical nurse) #4 stated the fluid restriction on Resident #29 was discontinued by the dietician, She stated she was going to talk with the NP (nurse practitioner) about this. When asked to provide evidence that the fluid restriction was discontinued, LPN #4 stated, "Let me search for it." On 11/1/23 at approximately 1:30 PM, Resident #29 was asked if his fistula was checked. Resident #29 stated, "Yes, they check the bruit and thrill." When asked if he takes a communication book with him to dialysis, Resident #29 stated, "Yes, they put papers in it here and at the dialysis center." When asked if he was on a fluid restriction, he stated he was not sure about that. He added: "I watch what I drink, though." On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. ASM #1 told the survey team there is no policy for dialysis care. A review of the facility's policy, ,"Resident Hydration and Prevention of Dehydration" revealed: "Physician orders to limit fluids will take priority over calculated fluid needs. The dietitian may refer calculated needs to the physician if restrictions potentially increase a risk for dehydration. Nursing will monitor and document fluid intake as ordered by the	F 698		

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F 698	Continued From page 42 physician/practitioner or per facility protocol. The dietitian will be kept informed of status. The interdisciplinary team will update the care plan and document resident response to interventions until the team agrees that fluid intake and relating factors are stabilized or resolved." A review of the facility's dialysis contract with Resident #29's provider revealed, "Facility will send to provider documentation as to how the patient's care is managed and all medical records necessary to provide services." No further information was provided prior to exit.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing	F 700	1. Resident #106 has discharged from the facility. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents with side rails was conducted to ensure review of the risks and benefits occurred, as well as informed consent was obtained. 3. DON/Designee provided education to licensed nursing staff regarding review of risks and benefits of side rails and obtaining informed consent for side rails. 4. DON/Designee will conduct an audit of current residents with newly implemented side rails to ensure review of risk and benefits, as well as consent was obtained. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/2023.	

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F 700	Continued From page 43 and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to implement bed rail requirements for one out of 34 residents in the survey sample, Resident # 106. The findings include: For Resident #106, the facility staff failed to evidence a review of the risks and benefits of bedrails, and failed to obtain informed consent for the use of the rails. Resident #106 was observed in bed with one quarter bed rail bilaterally on 10/31/23 at 12:00 PM, 11/1/23 at 9:00 AM, and 11/1/23 at 10:45 AM. The most recent MDS (minimum data set) assessment, a Medicare 5-day admission assessment, with an ARD (assessment reference date) of 10/11/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. In Section G, functional status, the resident was coded as being independent for bed mobility and transfers. A review of the clinical record revealed no evidence of a bed rail evaluation or informed consent for Resident #106. An interview was conducted on 10/31/23 at 12:00 PM with Resident #106. When asked if she used the bed rails, Resident #106 stated, "Yes, I use them to help turn and reposition myself."	F 700		

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F 700	Continued From page 44 An interview was conducted on 10/31/23 at 1:00 PM with LPN (licensed practical nurse) #3. When asked the process to be followed for a resident's bed rails, LPN #3 stated, "We do an assessment on the risks / benefits of the bed rails, obtain a consent and put it on the care plan." On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. A review of the facility's "Bed Rail Risk and Safety" policy revealed, "This organization will take measures to develop and implement a strategy to minimize the possibility of resident entrapment and or injury while using bed rails. This will include an evaluation of residents who have a need for or desire to use bed rails and that may have characteristics that place them at special risk for entrapment. If the resident's evaluation identifies him or her as appropriate for the use of bed rail(s), the following procedures will be followed: Educate the resident/resident representative on the risks and obtain consent for use. The resident and/or resident representative's consent for use of the bed rails will be documented in the medical record. The resident's representative will be notified as appropriate. The physician/practitioner will be notified and a specific order for the use of bed rails (identify how many / type of rails, which side or sides of the bed, and when they are to be in place) will be obtained. The reason for the bed rails and their proper use will be integrated into the comprehensive care plan and revised as	F 700		

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F 700	Continued From page 45 necessary." No further information was provided prior to exit.	F 700		
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 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	F 755	1. The provider was notified of the unavailable medication for resident # 35. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents receiving diabetic related medications was conducted to identify those that were unavailable over the last two weeks to ensure the provider was notified. 3. DON/Designee provided education to licensed nursing staff regarding notification of the provider for unavailable medication. 4. DON/Designee will perform an audit of current residents receiving diabetic related medications to identify those that were unavailable and ensure the provider was notified twice a week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of Compliance: 12/15/2023.	

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F 755	Continued From page 46	F 755		

by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to provide pharmacy services for one of 34 residents in the survey sample, Resident #35.

The findings include:

For Resident #35 (R35), the facility staff failed to ensure the medication Jardiance (1) was available for administration on 10/9/23 and 10/10/23.

A review of R35's clinical record revealed a physician's order dated 3/13/23 for Jardiance 25 mg (milligrams) by mouth one time a day for type two diabetes mellitus. A review of R35's October 2023 MAR (medication administration record) revealed the same physician's order for Jardiance. On 10/9/23 and 10/10/23, the MAR documented the code, "9= Other/ See Progress Notes." Nurses' notes dated 10/9/23 and 10/10/23 documented the medication Jardiance was not administered and was on order.

On 11/1/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated medications should be re-ordered from the pharmacy when there is a five-day supply of the medication left. LPN #4 stated that if a medication is not available for administration, then the nurses should pull the medication from the facility backup medication supply, and if the medication is not in the backup supply, then nurses should update the physician and resident's family.

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

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F 755	Continued From page 47 supply. On 11/1/23 at 4:41 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "General Guidelines for Medication Administration" documented, "Medications are administered as prescribed..." Reference: (1) Jardiance is used to lower blood sugar levels for people with diabetes mellitus. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a614043.html	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a medication error rate of less than 5% for one of 34 residents in the survey sample; Resident #94. The facility had two medication errors out of 35 opportunities, resulting in a medication error rate of 5.71%. The findings include:	F 759	1. A medication error was completed for resident #94. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. A medication administration competency was completed with LPN #5. 3. DON/Designee will perform a medication administration competency with licensed nursing staff. 4. DON/Designee will perform a medication administration competency with a randomly selected nurse twice a week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of Compliance: 12/15/2023.	

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F 759	Continued From page 48 For Resident #94, Humalog insulin was administered after breakfast instead of before breakfast, resulting in a medication error of not administering the medication at the right time as ordered by the physician. On 11/01/23 at 8:20 AM, the Medication Administration task was conducted with LPN #5 (Licensed Practical Nurse) for Resident #94. The following was observed: 1. Humalog (1) 10 units, scheduled, was administered after the resident had breakfast. 2. Humalog 2 units based on sliding scale, was administered after the resident had breakfast. A review of the clinical record revealed the following orders: 1. An order dated 7/27/23 for Humalog 10 units twice daily, before breakfast and lunch. 2. An order dated 7/7/23 for Humalog, dose per sliding scale, before breakfast and lunch. (Resident #94's glucose level was 217. The sliding scale dose order included, 200 - 249 = 2 units). When asked if Resident #94's insulin was administered in accordance with the physician's order of before breakfast, she stated it was not, because it was administered after breakfast. She stated that the resident won't take it before breakfast because he is afraid his glucose will drop. When asked if the doctor was aware of this, she stated that the doctor was aware but that this was still the order, so it should have been given before breakfast. When asked about the five rights of medication administration, she	F 759		

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F 759	Continued From page 49 stated "Right person, right medication, right dose, right route, right time." When asked if Resident #94's insulin was administered in accordance with those rights she stated it was not, because after breakfast was not the right time. A review of the comprehensive care plan dated 9/2/23 revealed, in part: "The resident has Diabetes Mellitus...Diabetes medication as ordered by doctor..." The facility policy, "General Guidelines for Medication Administration" was reviewed. This policy documented, "...6. At a minimum, the 5 Rights - right resident, right drug, right dose, right route, and right time - should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and the medication is put away...." On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Vice President of Operations, and LPN #1 the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. References: 1. Humalog is used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html	F 759		
F 842 SS=D	Resident Records - Identifiable Information	F 842		

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F 842	Continued From page 50 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842	1. The alleged deficient practice has already occurred and may not be retroactively corrected for resident #11 and #106. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents was completed to ensure the bathing and shower task is available for the nursing staff to complete documentation. 3. DON/Designee will education nursing staff regarding documentation of bathing/showers in the electronic medical record. 4. DON/Designee will perform an audit of 10% of current residents to ensure bathing/showering was documented as provided in the electronic medical record twice per week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/2023.	

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F 842	Continued From page 51 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide complete and accurate documentation for two of 34 residents in the survey sample, Residents #11 and #106. The findings include: 1. For Resident #11, the facility staff failed to evidence complete and accurate documentation	F 842		

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F 842	Continued From page 52 for showers/bathing. A review of the comprehensive care plan dated 2/3/23, which revealed, "FOCUS: Resident has an ADL (activities of daily living) self-care performance deficit related to weakness and right leg amputation. INTERVENTIONS: Provide supervision and cuing as needed with ADLs. Physical assist as needed with ADLs." A review of the ADL document in Resident #11's medical record, revealed documentation for showers was missing for 8/23/23 and 8/26/23. Shower documentation was also missing for 9/6/23, 9/30/23, 0/4/23, 10/7/23, 10/11/23, 10/18/23, 10/21/23, 10/25/23 and 10/28/23. An interview was conducted on 10/31/23 at 3:00 PM with Resident #11. Resident #11 stated, "They do not give me showers consistently. I do not think they like me." On 11/1/23 at approximately 11:00 AM, LPN (licensed practical nurse) #4 stated, "This is the documentation we have on Resident #11's showers." She provided indivdual shower sheet records Resident #11. When asked if this documentation is to be included in the electronic medical record, LPN #4 stated, "Yes, it is to be documented there." She stated if the documentation is not included in the electronic medical record, the medical record is not complete or accurate. An interview was conducted on 11/1/23 at 2:00 PM with CNA (certified nursing assistant) #2. When asked where shower and bathing are documented, CNA #1 stated, "We document it on the CNA form in [the electronic medical record]."	F 842		

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F 842	Continued From page 53 An interview was conducted on 11/2/23 at 8:00 AM with CNA #3. When asked where showers and bathing are documented, CNA #3 stated, "It is to be documented in [the electronic medical record. Sometimes we document it on the shower sheets." She stated if the documentation is not included in the electronic medical record, the medical record is not complete or accurate. On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. A review of the facility's "Charting and Documentation" policy, revealed, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." No further information was provided prior to exit. 2. For Resident #106, the facility staff failed to evidence complete and accurate record for resident weights. A review of the comprehensive care plan dated 10/6/23 revealed, "FOCUS: Resident is at risk for alteration in nutritional status related to new admission/facility adjustment, CKD, diuretic use for edema. INTERVENTIONS: Weights per	F 842		

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F 842	Continued From page 54 protocol." A review of the physician orders dated 10/6/23 revealed, "Daily Weight x3 days, Weekly Weight x4 weeks, then monthly." A review of the weight sheet in the electronic medical record and the October TAR (treatment administration record) revealed no evidence of weight documentation on 10/16/23, 10/23/23 and 10/30/23. On 11/1/23 at approximately 11:00 AM, LPN (licensed practical nurse) #4 stated, "This is the documentation we have on Resident #106's weights." She provided individual weight sheets for Resident #106. A review of the sheets for 10/19/23 and 10/26/23 revealed documentation that Resident #106 had refused to have weights done. When asked if this documentation is to be included in the electronic medical record, LPN #4 stated, "Yes, it is to be documented there." She stated if the documentation is not in the electronic medical record, the record is not complete or accurate. An interview was conducted on 11/2/23 at 8:00 AM with CNA (certified nursing assistant) #3. When asked where weights are documented, CNA #3 stated, "It is to be documented in [the electronic medical record." She stated sometimes the staff document it on the weight sheets. She stated if the weights are not documented in the electronic medical record, the record is not accurate or complete. On 11/1/23 at 4:32 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse	F 842		

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F 842	Continued From page 55 consultant, ASM # 4, the regional director of operations and LPN #1, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit.	F 842		