STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

(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 5/8/2023 through 5/10/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/08/2023 through 05/10/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two (2) complaints were investigated during the survey: Complaint VA00057391 with six allegations was unsubstantiated. Complaint VA00057566 with seven allegations was substantiated with deficiencies cited. The census in this sixty (60) certified bed facility was fifty-one (51) at the time of the survey. The survey sample consisted of thirteen (13) current resident reviews and three (3) closed record reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		6/23/23

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

Electronically Signed | 06/08/2023

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F 584	Continued From page 1 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to maintain floor mats and positioning cushions in clean/intact condition for one of sixteen residents in the survey sample (Resident #4).	F 584	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and	

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F 584	Continued From page 2 The findings include: Resident #4's floor mats were dirty, and the surfaces were heavily torn with frayed edges. The coverings on the bolster cushions in Resident #4's bed had torn corners with exposed foam visible. Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated 3/14/23 assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/9/23 at 10:02 a.m., floor mats were observed on Resident #4's side of the room. One mat was observed rolled up by the bedside table and the other mat was under the resident's bed. The covers of both mats were dirty and worn with visible cracks over the entire mat surface. The edges of both mats were tattered and frayed. On 5/9/23 at 2:18 p.m., the licensed practical nurse (LPN #6) caring for Resident #4 was interviewed about the condition of the floor mats. LPN #6 stated, "They [mats] are in pretty bad shape." LPN #6 stated that she was not sure if new mats were kept in the supply room. On 5/9/23 at 2:29 p.m., accompanied by LPN #6, two bolster cushions on Resident #4's bed were observed. The coverings on both cushions were torn on the corners with exposed foam visible. LPN #6 stated at this time that the floor mats	F 584	state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 584 1- Resident #4 was issued new bed bolsters and floor mats for both sides of bed. The torn/tattered bolster and mats were discarded. 2- All residents are at risk for deficient practice related to wear and tear of padded devices. Facility audit for use of devices performed. Residents utilizing bolsters and/or floor mats were assessed for the need for new products and any products found torn/tattered/dirty were replaced. 3- DON or designee provided in-service to direct care and housekeeping staff on reporting damaged/dirty bolsters/matts/etc. 4- DON or designee weekly device audits x 4, then monthly x2 to ensure that devices are properly maintained. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. 6- Completion Date: 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 584	Continued From page 3 were "ragged" and the torn cushion covers needed replacing. On 5/9/23 at 2:45 p.m., the unit manager (LPN #2) was interviewed about the floor mats and bolster cushions being in poor condition. LPN #2 stated any mats and/or cushions with hole or rips were supposed to be immediately replaced. LPN #2 stated that it was not sanitary to use cushions with torn coverings. LPN #2 stated Resident #4's mats and the bolster cushions needed to be discarded and replaced. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information about the torn/tattered mats/cushions prior to the end of the survey.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		6/23/23

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F 607	Continued From page 4 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to identify and report an injury of unknown origin to the appropriate facility staff for one of 16 residents, Resident #258. Findings were: Resident #258 was admitted to the facility with the following diagnoses, including but not limited to, Atrial fibrillation, dementia, psychotic disturbance, mood disturbance, anxiety, and urinary tract infection. Due to her recent admission, no MDS (minimum data set) information was available. Upon attempted interview with Resident #258, her speech was nonsensical and she was unable to answer questions. On 05/08/2023 at approximately 12:15 p.m., the initial tour of the facility was conducted. Resident #258 was observed sitting in a wheelchair outside of her room. An elongated area was observed on the right side of her head, from her scalp, down	F 607	F 607 1. Resident #258□s skin was assessed by the UM and the DON. The Administrator initiated an investigation immediately to determine the report of bruising of unknown origin. Staff were educated on reporting injuries of unknown origin to the appropriate staff by the SDC. 2. All residents are at risk for deficient practice. The incident reports, progress notes and skin assessments will be reviewed by the DON to ensure that any any injuries of unknown origin are reported appropriately. 3. The Staff Development Coordinator or designee will provide in-services to all staff on timely reporting and documentation of injuries of unknown origin. 4. The Administrator or designee will complete weekly audits x4, then monthly x2 to ensure that injuries of unknown origin are reported appropriately. 5. Results of the audits will be presented	

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F 607	Continued From page 5 her forehead, running parallel to her hair line. The area was bluish/purple in color. When asked what had happened to her head, Resident #258 answered, "I don't know it's [Name redacted]'s choir...they know." CNA (certified nursing assistant) #3 was in the hallway with Resident #258 and was asked about the bruise. CNA #3 stated that Resident #258 was a fall risk and that "she falls". When asked if she had hit her head during a fall, Resident #258 again answered the question with a reference to [Name redacted]'s choir. The clinical record was reviewed on 05/09/2023 at approximately 11:00 a.m. There was no documentation observed regarding the discolored area on Resident #258's forehead. The admission assessment completed on 05/01/2023 was reviewed. The section "Skin Observations" assessed Resident #258 as having no skin issues. At approximately 3:00 p.m., LPN (licensed practical nurse) #1 was interviewed regarding the area of discoloration on Resident #258's forehead. LPN #1 stated that she had done the admission assessment and documentation for Resident #258 and had not seen the area at that time. LPN #1 and this surveyor went to Resident #258's room. Resident #258 was lying supine on her bed. The area on her forehead was observed with more green coloring with the same elongated shape described above. LPN #1 stated, "I haven't seen that before...it wasn't there when she came in." At approximately 3:15 p.m., the DON (director of	F 607	to the QAPI Committee for review and recommendation. 6. Completion Date: 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 607	Continued From page 6	F 607		

nursing), the administrator, and the regional nurse consultant were all in the DON's office. They were asked if anyone had reported the area on Resident #258's forehead to them. The administrator and the DON both stated that they had not been made aware of any discoloration.

During an end of the day meeting with the DON, the administrator, and the regional nurse consultant the above information was discussed. The DON stated they were still investigating to see if they could find out what had happened. When asked if the area should have been reported to him by they facility staff, the Administrator stated, "Yes."

On 05/10/2023 at approximately 8:50 a.m., CNA #3 was interviewed regarding the area on Resident #258's forehead. When asked if he had noticed the area when he was taking care of her, CNA#3 stated, "Yes, I saw it." When asked if he had reported it to his charge nurse when he first noticed it, CNA #3 stated, "No, I thought it looked old, so I thought they already knew about it."

At approximately 9:00 a.m. the DON and the regional nurse consultant were interviewed regarding Resident #258. The regional nurse consultant stated, "We are still looking into it...the therapist said he noticed it last Friday...her son said he noticed it on Saturday...she had a fall here on May 5th...the documentation is that she fell on her bottom..." When asked if the therapist or the resident's son had told any one about the area, the regional nurse consultant stated, "No."

At approximately 10:25 a.m., a skin observation tool completed on 05/09/2023 at 6:21 p.m. was presented by the unit manager, LPN #2. The skin

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F 607	Continued From page 7	F 607		

observation tool contained the following:
Top of Scalp: Bruising
Left hand (back): Bruising
Right knee (front): Bruising
Left knee (front): Bruising
Right top foot: Bruising
Notes: Head to toe Skin sweep Resident noted to have a bruise to her right temple area blue, yellow greenish in color. Yellowish bruise noted to left wrist, yellowish bruise noted to left shin area, blue bruise noted to right knee and a reddened area noted to the top of her right foot under metatarsals no open area noted, nor drainage noted. Dr [name redacted] called and notified at this time of head-to-toe skin sweep and finding."

LPN #2 stated, "I did the skin sweep last night, I called the doctor to let him know about the bruises that I saw..the staff should have reported what they were seeing."

The facility policy, "Injuries of Unknown Origin" contained the following: "Injuries of unknown origin will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the center Administrator. Procedure: Injuries of unknown origin to a patient are to be reported to a licensed nurse."

The staff educator, RN (registered nurse) #3 was interviewed at approximately 10:30 a.m. regarding staff education about injuries of unknown origin. RN#3 presented an "Inservice/Educational Record" that education had occurred on 03/09/2023 with nursing staff and included information regarding injuries of unknown origin.

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F 607	Continued From page 8 The above information was discussed with the DON, the administrator, and the regional nurse consultant during a meeting at approximately 11:30 a.m. No further information was presented prior to the exit conference on 05/10/2023.	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		6/23/23

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F 623	Continued From page 9	F 623		

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

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F 623	Continued From page 10 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on complaint investigation, closed clinical record review, and staff interview, the facility staff failed for one of 16 residents in the survey sample, Resident # 107, to forward a notice of discharge to the local Ombudsman. Resident # 107 was transferred to the hospital without a notice of discharge being sent to the local Ombudsman. The findings were: Resident # 107, who was her own Responsible	F 623	F 623 1. Resident #107 was discharged from the facility. The Ombudsman was notified of transfers of all current residents. 2. All residents are at risk for deficient practice related to notice requirements for transfer/discharge. Residents admitted to the facility within the past 30 days were reviewed for hospital transfer/discharge and notice sent to Ombudsman by the Administrator. 3. The Administrator or designee will	

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F 623	Continued From page 11 Party, was admitted to the facility with diagnoses that included status post left femur fracture, history of malignant neoplasm of the breast, hypothyroidism, depression, hypertension, difficulty walking, generalized muscle weakness, anxiety disorder, peripheral vertigo, chronic obstructive pulmonary disease, right hip pain, chronic respiratory failure with hypoxia, and COVID-19. The Progress Notes in the resident's Electronic Health Record included the following entries: 12/30/2022 - 1930 (7:30 p.m.) - "O2 (oxygen) sat (saturation) reported @ 75% on 5L/M (5 liters per minute). Resident positioned sitting up, alert and oriented. Administered prn (as needed) Duoneb treatment and titrated oxygen to 8L/M via nasal cannula. O2 sat increased to 88%. TC (Telephone Call) to on call MD, (name), and received order to transfer Resident to ED. Resident left facility via EMS transport to Lynchburg General @ 2020 (8:20 p.m.). Daughter notified of Resident's change in condition approx(imately) 2000 (8:00 p.m.)." 12/31/2022 - 0431 (4:31 a.m.) - "Spoke with (name) at Centra Lynchburg ER resident being admitted for Acute respiratory failure." Resident # 107 did not return to the facility. At approximately 2:30 p.m. on 5/9/2023, the facility Administrator was asked for a copy of the resident's transfer notice sent to the local Ombudsman. The Administrator stated that the Discharge Planner/Social Worker who handles that process was no longer employed at the facility, but that he would try to locate the notice.	F 623	provide in-services to administrative facility staff on the process of reporting hospital transfer/discharges to Ombudsman. 4. The Administrator or designee will perform weekly audits x 4, then monthly x2 to ensure compliance of proper notification of resident transfers or discharges to the Ombudsman. 5. Results of the audits will be presented to the QAPI Committee for review and recommendation. 6. Completion Date: 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 623	Continued From page 12 At 10:50 a.m. on 5/10/2023, the Administrator reported that he was unable to find the transfer notice sent to the local Ombudsman. The lack of a transfer notice was discussed at a 10:30 a.m. meeting on 5/10/2023 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F 623		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure admission orders were in place for the care of suprapubic catheter for one of 16 residents, Resident #257. Findings were: Resident #257 was admitted to the facility with the following diagnoses including but not limited to: hypertension, pulmonary edema, protein-calorie malnutrition, anemia, pneumonia, urethral stricture, and pseudomonas pneumonia. Due to his recent admission, no MDS (minimum data set) information was available. When interviewed, regarding his care at the facility Resident #257 answered questions appropriately. During initial tour of the facility on 05/08/2023 at	F 635	F 635 1. Resident #257 had orders updated for care of the suprapubic catheter. 2. All residents are at risk for deficient practice related to not having orders for the care of a suprapubic catheter. The DON or designee will review current residents with suprapubic catheters to ensue that appropriate orders are in place for the care of the suprapubic catheter. 3. The SDC or designee will provide in-services to licensed nursing staff on the need for orders for suprapubic care. 4. The Unit Manager or designee will complete weekly audits x 4, then monthly x2 to insure physician orders are in place for the care of suprapubic catheters. 5. Results of the audits will be presented to the QAPI Committee for review and recommendation.	6/23/23

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F 635	Continued From page 13 approximately 12:15 .pm., Resident #257 was observed lying supine on his bed. His pajama top was not pulled all the way down and a suprapubic catheter was observed. The clinical record was reviewed on 05/08/2023 at approximately 2:30 p.m. The physician order section contained the following order for the care of the suprapubic catheter: "Cleanse and apply split sponge to suprapubic site daily..." The care plan was reviewed. A focus area, "The resident requires an urinary suprapubic catheter related to : Obstructive uropathy." The interventions listed was to provide catheter care each shift. An end of day meeting was held on 05/09/2023 at approximately 4:00 p.m. with the DON (Director of Nursing), the administrator, and the regional nurse consultant. The DON was asked if the facility was changing Resident #257's catheter or was he going out of the facility. The DON stated that she didn't know but would check. Concerns were voiced that there were no immediate care orders on the clinical record that addressed what to do if the catheter became clogged or dislodged, nor were there interventions on the care plan to address these concerns. The DON stated that she would find out what was supposed to be done. On 05/10/2023 the facility staff presented an updated care plan that included care of the catheter, and physician orders that included, "Nursing staff not to change suprapubic catheter, urology will manage." No further information was obtained prior to the	F 635	6. Completion Date: 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction	

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F 635	Continued From page 14 exit conference on 05/10/2023.	F 635		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		6/23/23

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F 655	Continued From page 15 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a baseline care plan for the care of suprapubic catheter was in place for one of 16 residents, Resident #257. Findings were: Resident #257 was admitted to the facility with the following diagnoses including but not limited to: hypertension, pulmonary edema, protein-calorie malnutrition, anemia, pneumonia, urethral stricture, and pseudomonas pneumonia. Due to his recent admission, no MDS (minimum data set) information was available. When interviewed, regarding his care at the facility Resident #257 answered questions appropriately. During initial tour of the facility on 05/08/2023 at approximately 12:15 p.m., Resident #257 was observed lying supine on his bed. His pajama top was not pulled all the way down and a suprapubic catheter was observed. The clinical record was reviewed on 05/08/2023 at approximately 2:30 p.m. The physician order section contained the following orders for the care of the suprapubic catheter: "Cleanse and apply	F 655	F 655 1. The care plan was updated for Resident #257 to include the care of the suprapubic catheter. 2- All residents are at risk for deficient practice related to not having a baseline care plan developed for the care of a suprapubic catheter by the DON, or designee. 3-The DON or designee will educate Licensed Nurses on the development of a baseline care plan, to include the care of suprapubic catheters. 4-The Unit Manager, or designee will complete weekly audits x4, then monthly x2 of residents with suprapubic catheters to ensure that the care of the suprapubic catheter is reflected on the care plan. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6- Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 655	Continued From page 16 split sponge to suprapubic site daily..." The care plan was reviewed. A focus area, "The resident requires an urinary suprapubic catheter related to : Obstructive uropathy." Interventions listed were to provide catheter care each shift. An end of day meeting was held on 05/09/2023 at approximately 4:00 p.m. with the DON (Director of Nursing), the administrator, and the regional nurse consultant. The DON was asked if the facility was changing Resident #257's catheter or was he going out of the facility. She stated she didn't know but would check. Concerns were voiced that there were no immediate care orders on the clinical record regarding the care of the catheter nor were there any interventions regarding replacement listed on the care plan. The DON stated that she would find out what was supposed to be done. On 05/10/2023 the facility staff presented an updated care plan that included care of the catheter, and physician orders that included, "Nursing staff not to change suprapubic catheter, urology will manage." No further information was obtained prior to the exit conference on 05/10/2023.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		6/23/23

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F 656	Continued From page 17	F 656		

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 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.

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F 656	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of sixteen residents in the survey sample (Resident #4). The findings include: Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated 3/14/23 assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/9/23 at 2:34 p.m., Resident #4 was observed seated in a wheelchair in his room. The resident had a pommel seat cushion in use with the wheelchair. Review of Resident #4's clinical record revealed an occupational therapy (OT) discharge summary dated 4/3/23 recommending use of the pommel cushion to assist with proper positioning and fall prevention when in the wheelchair. Resident #4's plan of care (revised 4/5/23) listed, "Pommel cushion for positioning PRN [as needed], reposition as needed" as an intervention related to maintaining activities of daily living. The plan of care included no problems, goals and/or interventions regarding use of the pommel cushion and the pommel cushion was not included among interventions regarding fall/injury	F 656	F 656 1- The care plan was revised to include the pommel cushion for Resident #4. 2- All residents are at risk for deficient practice related to not having a comprehensive care plan developed to address the use of devices. Current residents with devices will be reviewed by the DON, or designee to ensure that the device use is addressed on the resident care plan. 3-The DON, or designee will educate Licensed Nurses on including a focus area, goal and interventions on the resident care plan to address the use of devices. 4-The DON, or designee will complete weekly audits x4, then monthly x2 of care plans for the inclusion of devices. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation 6- Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 656	Continued From page 19 prevention. On 5/9/23 at 3:13 p.m., the director of nursing (DON) was interviewed about a plan of care for Resident #4's pommel cushion use. The DON stated the device required a plan of care. The DON stated the pommel cushion was a recommendation from OT for fall prevention due to the resident's improper positioning when seated in the wheelchair. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information about a care plan regarding the pommel cushion prior to the end of the survey.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		6/23/23

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F 657	Continued From page 20 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to revise the comprehensive care plan for one of sixteen residents in the survey sample (Resident #41). The findings include: Resident #41's plan of care was not revised regarding discontinued use of a Foley urinary catheter. Resident #41 was admitted to the facility with diagnoses that included vertebra compression fractures, atrial fibrillation, sepsis, pneumonitis, urinary tract infection, atherosclerotic heart disease, anxiety, asthma, congestive heart failure, urine retention and kidney failure. The minimum data set (MDS) dated 2/27/23 assessed Resident #41 as cognitively intact. Resident #41's plan of care (revised 4/19/23) documented the resident required a urinary catheter due to retention and diagnosed bladder infection. Interventions to prevent catheter complications and resolve infection included changing catheter as ordered, anchoring catheter, provision of privacy bag, monitoring	F 657	F 657 1- The care plan was revised to indicate that the resident no longer requires foley catheter use for Resident #41. 2- All residents are at risk for deficient practice related to not having a care plan reviewed and revised appropriately. The DON, or designee will review current residents with foley catheters to ensure that the care plan is updated appropriately. 3-The DON, or designee will educate Licensed Nurses on revising comprehensive care plans with resident changes of foley catheters. 4-The DON or designee will complete weekly audits x4, then monthly x2 of resident care plans to ensure that any resident foley catheter changes are updated on the care plan. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation 6- Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 657	Continued From page 21 urine for dark or cloudy appearance, and catheter care every shift and per orders. Review of Resident #41's clinical record revealed no current order for a Foley urinary catheter. On 5/8/23 at 3:00 p.m., Resident #41 was interviewed about the urinary catheter. Resident #41 stated she previously had a catheter due to retention problems, but the catheter had been discontinued and she was voiding without problem. Resident #41 stated the catheter had been taken out over a month ago. On 5/8/23 at 3:15 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about the Foley catheter. LPN #2 stated the resident no longer had a catheter. LPN #2 looked at the clinical record and stated the catheter was discontinued on 3/22/23. On 5/10/23 at 8:21 a.m., the registered nurse MDS coordinator (RN #6) responsible for care plans was interviewed. RN #6 stated the last care plan meeting for Resident #41 was on 4/26/23. RN #6 stated the care plan items about the catheter should have been removed when the device was discontinued. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/10/23 at 11:25 a.m. No further information was provided about Resident #41's care plan prior to end of the survey.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		6/23/23

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F 684	Continued From page 22 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, closed clinical record review, staff interview, and review of facility documents, the facility staff failed for one of 16 residents in the survey sample, Resident # 107, to administer medications in a timely manner. Six medications, administered by two different nurses, were given between 2 hours and 43 minutes, and 4 hours and 45 minutes late. The findings were: Resident # 107, who was her own Responsible Party, was admitted to the facility with diagnoses that included status post left femur fracture, history of malignant neoplasm of the breast, hypothyroidism, depression, hypertension, difficulty walking, generalized muscle weakness, anxiety disorder, peripheral vertigo, chronic obstructive pulmonary disease, right hip pain, chronic respiratory failure with hypoxia, and COVID-19. As a part of the complaint investigation process, the Medication Admin Audit Report was reviewed. Review of the report revealed the following medications were administered late. Docusate Sodium Capsule 100 mg (milligrams) - Give 1 capsule by mouth two times a day for	F 684	F 684 1-Resident #107 is discharged from the facility 2- All residents receiving medications are at risk for deficient practice related to the need to administer medications in accordance with physician orders. The medication administration report of Current residents will be reviewed by the DON or designee to ensure that medications are administered within the ordered timeline. 3-The Staff Development Coordinator, or designee will educate Licensed Nurses on the Medication Administration policy related to following physician orders for time of dose. 4-The DON, or designee will complete weekly audits x4, then monthly x2 of the Medication Administration Documentation report to ensure that medications are given timely. Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23	F 684		

constipation.
Scheduled Administration time - 4:00 p.m.
Administration Time - 8:44 p.m.
Time Documented - 8:45 p.m.
Time late - 4 hours, 44 minutes

Carvedilol Tablet 3.125 mg - Give 1 tablet by mouth two times a day for Hypertension.
Scheduled Administration time - 4:00 p.m.
Administration Time - 8:44 p.m.
Time Documented - 8:45 p.m.
Time late - 4 hours, 44 minutes

Aspirin 81 Tablet Chewable 81 mg - Give 1 tablet by mouth two times a day for supplement for 30 days.
Scheduled Administration time - 4:00 p.m.
Administration Time - 8:45 p.m.
Time Documented - 8:45 p.m.
Time late - 4 hours, 45 minutes

Donepezil HCl Tablet 5 mg - Give 1 tablet by mouth two times a day for dementia.
Scheduled Administration time - 4:00 p.m.
Administration Time - 8:45 p.m.
Time Documented - 8:46 p.m.
Time late - 4 hours, 45 minutes

Calcium Carbonate-Vitamin D3 Tablet 600-400 mg - Give 1 tablet by mouth with meals for supplement.
Scheduled Administration time - 5:00 p.m.
Administration Time - 8:45 p.m.
Time Documented - 8:45 p.m.
Time late - 3 hours, 45 minutes

At approximately 6:00 p.m. on 5/9/2023, LPN # 3 (Licensed Practical Nurse) was interviewed by telephone. LPN # 3 was identified on the Audit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 24	F 684		

Report as the staff member who administered the five medications. Review of the Medication Administration Report (MAR) for the month of December 2022 revealed LPN # 3's initials were on the MAR as having administered the medications.

Asked if she remembered Resident # 107, :LPN # 3 said, "I have no recollection." When asked why the medications were administered late, LPN # 3 said, "I'm usually pretty good about giving meds (medications) on time. Maybe it was a computer problem."

Further review of the Medication Admin Audit Report revealed the following medication was administered late:

Hydrocodone-Acetaminophen Tablet 5-325 mg - Give 1 tablet by mouth every 8 hours for pain for 7 days.
Scheduled Administration time - 4:00 p.m.
Administration Time - 6:43 p.m.
Time Documented - 6:44 p.m.
Time late - 2 hours, 43 minutes

According to the MAR, Resident # 107's pain level at the time of administration was 9 on a scale of 0 to 10.

At approximately 11:00 a.m. on 5/10/2023, LPN # 7 was interviewed by telephone. LPN # 7 was identified on the Audit Report as the staff member who administered the pain medication. Review of the Medication Administration Report (MAR) for the month of December 2022 revealed LPN # 7's initials were on the MAR as having administered the pain medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 684	Continued From page 25 Asked about Resident # 107, LPN #7 said she did not remember her. When asked why the pain medication was administered late, LPN # 7 said, "I don't recall. I know it was very busy. I might have given it but didn't document it until later." "The six rights of medication administration include the following: 1. The right medication. 2. The right dose. 3. The right client. 4. The right route. 5. The right time. 6. The right documentation." (Ref.: Fundamentals of Nursing, Potter-Perry, 7th Edition, Chapter 35, page 707,) The findings were discussed at a 10:30 a.m. meeting on 5/10/2023 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		6/23/23

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F 686	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed to follow physician orders for the treatment of a pressure ulcer for one of 23 resident's. Resident #6 did not have physician ordered elbow protector in place. The Findings Include: Diagnoses for Resident #6 included; Hemiplegia, contractures, bursa right elbow, dementia, and pressure ulcers. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/30/23. Resident #6 was assessed with long and short-term memory problems and severely cognitively impaired. On 5/8/23 Resident #6's clinical record was reviewed. An active physician's order read: "Right Elbow: Cleanse with wound cleanser, pat dry, Apply Silver Alginate, Collagen Particles, cover with kerlix and elbow protector." Review of Resident #6's most recent skin assessment dated 5/8/23 documented Resident #6 had a stage 4 pressure ulcer to the right elbow. On 5/8/23 at 2:25 PM Resident #6 was observed lying in bed with a dressing to the right elbow but did not have an elbow protector in place. On 5/09/23 at 10:31 AM during observation of a dressing change to Resident #6's right foot, Resident #6 was again observed without an the	F 686	F686 1-Resident #6 is receiving elbow protectors for pressure ulcer as ordered. 2-All residents receiving wound care are at risk for deficient practice related to not having devices in place for the treatment of pressure ulcers. The DON, or designee will review current residents with pressure ulcers to ensure that ordered devices are in place for the treatment of pressure ulcers. 3-The DON, or designee will educate Licensed Nurses on following physician orders for placement of elbow protectors or other devices for the treatment of pressure ulcers and addressing concerns if elbow protectors not in place. The CNA□s will be educated on notifying the Nurse if elbow protectors not in place. 4-The DON, or designee will complete weekly audits x4 weeks, then monthly x2 of residents with elbow protectors and other ordered devices for pressure ulcers to ensure that they are in place, as ordered. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 686	Continued From page 27 elbow protector and the dressing to the elbow had started to come loose. At this time license practical nurse (LPN #4) and certified nursing assistant (CNA #1) was asked about the elbow protector. LPN #4 verbalized unawareness that the protector was not in place. CNA #1 verbalized Resident #6 rubs against the pillow and causes the dressing to come off and also verbalized, she wasn't currently assigned to Resident #6, but said the elbow protector was hard to apply. LPN #4 and CNA #1 was asked to locate the elbow protector. After looking around Resident #6's room the protector could not be located. On 5/09/23 at 10:58 AM CNA #2 (CNA assigned to Resident #6) was asked to look for elbow protector but could not find it. CNA #2 said that she has not seen the protector and has had a hard time putting the protector on in the past. CNA #2 was asked if the nurse had been notified that the aides were having a hard time applying the protector. CNA #2 verbalized she had not reported it. On 5/09/23 at 4:18 PM the above information was presented to the administrator, director of nursing, and regional nurse. No other information was provided prior to exit conference on 5/10/23.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/23/23

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 689	Continued From page 28 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement safety interventions consistent with the individualized needs and standards of practice for one of sixteen residents (Resident #4). Staff failed to appropriately position the safety interventions (bilateral floor mats) identified in Resident #4's care plan. In addition to the ongoing monitoring of effectiveness, Staff failed to perform a risk/safety assessment prior to implementing devices. The findings include: Resident #4 was observed in bed without protective floor mats being positioned properly as required in the plan of care for injury prevention. Resident #4 had bed bolster cushions in use for over six weeks without having a safety assessment prior to implementation. Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated 3/14/23 assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/8/23 at 2:05 p.m., Resident #4 was	F 689	F 689 1. Resident #4 had floor mats placed and positioned correctly. A Device assessment was completed to ensure appropriate use of matts and bolsters. 2. All residents utilizing devices at risk for deficient practice related to device assessment not performed and not having the devices in place. The DON, or designee will review current residents to ensure device assessments completed and that the devices are in place. 3. The DON or designee will educate Licensed Nursing staff on completion of an assessment for devices and ensuring that the devices are in place for the residents. The CNA□s will be educated on ensuring devices are in place. 4. 4-The DON, or designee will complete weekly audits x4, then monthly x 2 of residents with devices to ensure assessments are in place. 5. Results of the audits will be presented to the QAPI Committee for review and recommendation. 6. 6-Completion date 6/23/2023 7. The Admin/DON are responsible for implementation of the plan of correction.	

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F 689	Continued From page 29	F 689		

observed in bed. There were cushioned bolsters on each side of the resident positioned between the resident and bed rails. No floor mats were positioned on the floor on either side of the bed. One mat was observed rolled up by the bedside table and the other mat was under the resident's bed. Resident #4 was observed again in bed on 5/8/23 at 2:50 p.m. and 3:43 p.m. with the bolster cushions in use and no floor mats on either side of the bed.

Resident #4's clinical record documented a history of falls from the bed. Nursing notes documented the following falls.

1/07/23 - "...Resident experienced a witnessed fall...located in resident room. No injuries noted..."
1/23/23 - "...Resident rolled out of bed on to floor in room. No injury noted..."
2/19/23 - "...found resident lying on the left side of the bed on his right side (on the side of the fall mat)...booster [bolster] to right side of bed in place, booter [bolster] to left side of bed in floor. grip socks in place...unwitnessed fall to right side, c/o [complained of] hip pain and was sent to hospital..."
3/10/23 - "...Roommate of resident was yelling that resident had fallen out of the bed. Resident was found in room...w/ [with] upper half of body outside of the bed and on the floor, w/ feet remaining in the bed. His head was off of the floor...no injuries..."
3/12/23 - "...residnet [resident] was found lying next to bed on the floor, no injuries noted and no pain noted..."
3/20/23 - "....Resident experienced witnessed fall... no apparent injuries..."
5/02/23 - "...Nurse went to check on this

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F 689	Continued From page 30	F 689		

Resident, He was noted to be on the Fall Mat laying on His Left Side..."

Resident #4's plan of care (revised 5/5/23) documented the resident was at risk for falls related to cognitive impairment, had a fall history, assistance required for transfers and poor safety awareness. Interventions listed to prevent falls/injuries included, "...fall mats to side of bed...place bed in lowest position while resident is in bed...place common items within reach of the resident...remind the resident to use their call light...Bed bolsters PRN [as needed]...Ensure positioning in middle of bed after ADL care..."

Resident #4's clinical record documented the bed bolster cushions were added to the care plan on 3/21/23. The clinical record documented no device assessment for use of the bolster cushions.

On 5/9/23 at 2:13 p.m., CNA #5 caring for Resident #4 was interviewed about the floor mats and bolster cushions. CNA #5 stated that the protective mats were supposed to be on the floor, on each side of the bed, when Resident #4 was in bed.

On 5/9/23 at 2:16 p.m., CNA #3 that cared for Resident #4 during the day shift on 5/8/23 was interviewed. CNA #3 stated that the floor mats were supposed to be by Resident #4's bed because the resident had frequent falls. CNA #3 stated that he did not place the mats by the bed yesterday (5/8/23) because there was "lots of coming and going" in his room. When asked to explain, CNA #3 stated staff were "in and out" of the resident's room and he had not placed the mats by the bed.

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F 689	Continued From page 31	F 689		

On 5/9/23 at 2:18 p.m., licensed practical nurse (LPN #6) caring for Resident #4 on 5/8/23 was interviewed. LPN #6 stated that she did not notice that the mats were not in place yesterday (5/8/23). LPN #6 stated that the mats were used for injury prevention because the resident had experienced multiple falls from the bed. LPN #6 stated the bolsters were used to help prevent the resident from rolling out of bed, but she was not sure how long they had been in use.

On 5/9/23 at 2:45 p.m., the unit manager (LPN #2) stated the bolster cushions were a nursing intervention added in attempt to prevent falls from the bed. LPN #2 stated the mats were supposed to be in place when the resident was in bed for injury prevention in case of a fall.

On 5/9/23 at 3:47 the director of nursing (DON) was interviewed about an assessment for the bolsters. After investigating, the DON stated the bolster cushions were added for fall prevention and no assessment had been completed for the resident's use of the cushions.

The facility's policy titled Device Assessment/Bed Safety (effective 11/1/19) documented, "The Device Assessment will be completed to provide documentation of the needs, and risk factors involved in the use of a restraint or device used by the patient...The assessment is to be completed by a licensed nurse before initiation of any restraint or device. The assessment will be reviewed and revised quarterly, annually, and with any significant changes...The specific type and reason for use of the device or restraint will be documented on the Device Assessment..."

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 689	Continued From page 32 This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information regarding the out of place mats or a bolster cushion assessment.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation , resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure adequate nutritional needs for the prevention of weight loss for one of 16 residents, Resident #1.	F 692	F 692 1. Resident #1 was re-assessed by the IDT team for weight loss and necessary nutritional needs. Additional interventions were provided to address weight loss and the resident has not had any further	6/23/23

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 692	Continued From page 33 Findings were: Resident #1 was admitted to the facility with the following diagnoses, including but not limited to: encephalopathy, diabetes mellitus, COPD (chronic obstructive pulmonary disease), major depressive disorder, vascular dementia, hypertension, and hypothyroidism. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/26/2023, assessed Resident #1 as moderately impaired with a cognitive summary score of "09" out of 15. 05/08/2023, Resident #1 was observed while finishing lunch in his room. Resident #1 had eaten 100% of the meal tray. When was asked about still being hungry, Resident #1 stated that he would like some milk. Resident #1 added, "I like milk, but they don't give it to me." The clinical record was reviewed on 05/08/2023 at approximately 3:00 p.m. The weight section was reviewed and contained the following: 12/01/2022: 204.3 12/06/2022: 205.1 12/26/2022: 192.6 01/04/2023: 195 01/16/2023: 196.2 01/23/2023: 181.3 01/23/2023: 180.9 01/30/2023: 180.6 02/01/2023: 182.6 03/31/2023: 183.5 04/03/2023: 183.5 05/01/2023: 183.5 Resident #1's weight on 12/01/2022 was listed as 204.3 pounds. His most recent weight was 183.5	F 692	weight loss. 2. All residents are at risk for deficient practice related to weight loss and not receiving the appropriate nutritional needs address weight loss. The DON, or designee will review current residents with weight loss to ensure that appropriate interventions are in place for the residents to address the weight loss and that those identified residents are receiving adequate nutrition for the prevention of weight loss. 3. The DON or designee will educate IDT team and licensed nursing staff on ensuring that residents with weight loss are receiving the appropriate nutritional needs to prevent further weight loss. 4. The DON, or designee will complete weekly audits x 4, then on a monthly basis of residents triggering for weight loss to ensure appropriate assessments and interventions are ordered to meet nutritional needs. 5. Results of the audits will be presented to the QAPI Committee for review and recommendation. 6. 6-Completion date 6/23/2023 7. The Admin/DON are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 692	Continued From page 34	F 692		

pounds on 05/01/2023, a loss of 20.8 pounds or 10.18% in six months.

The physician order section was reviewed and contained a diet order for "Heart Healthy Diet, dysphagia, mechanically altered texture, Regular liquids consistency, weighted utensils". Also observed was an order for "House supplement two times a day for prevention of malnutrition and history or weight loss", dated 01/26/2023.

On 05/09/2023 at approximately 8:15 a.m., Resident #1 was observed with his breakfast tray. His tray contained pureed eggs and oatmeal. He had a small Styrofoam cup of orange juice. His tray card was observed and contained the following:
Heart Healthy Dysphagia Diet Mechanically Altered
Orange Juice: 4 oz
Scrambled Egg Substitute: 2 ounces
Slivered Green Onions: 1 tablespoon
Grits: 8 oz
2% Milk: 8 ounces
Hot Coffee or Hot Tea: 6 ounces

When asked if the coffee, tea, or milk had been on his tray, Resident #1 stated, "No." When asked what he would like, Resident #1 stated, "Milk". CNA (certified nursing assistant) #4 was in the hallway and was asked if she knew why Resident #1 didn't have any milk. CNA #4 stated, "The drinks come on a separate cart." When asked if she had looked at Resident #1's tray card, CNA #4 stated, "No, I just get them what they tell me they want." When asked to provide Resident #1 with some milk per his request, CNA #4 returned to the room with a Styrofoam cup containing milk. There was no lid on the cup.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

(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 692	Continued From page 35	F 692		

Attempting to drink, Resident #1 was observed with marked shaking of both his right and left hands, spilling more than half of his milk in his lap as he tried to drink it. Resident #1 stated, "I'm making a mess, I am sorry."

On 05/09/2023 at approximately 11:00 a.m., the RD (registered dietitian) was interviewed When asked about Resident #1's weight loss, the RD stated that Resident #1 had broken his hip in December and was hospitalized for surgical repair. The RD stated that Resident #1 had also had pneumonia in January that required a couple of days in the hospital. The RD stated, "I put him on supplements in January when he got back and his weight came up some..he has stabilized." When asked what was the ordered diet, the RD stated, "Heart healthy, mechanically altered. Meats should be ground with gravy on them...bread and and bread products should be pureed." Asked if that should include the pureed eggs served that morning, the RD stated, "No, he can have scrambled eggs." When asked why the diet specified 2% milk following the apparent weight loss, the RD stated, "I didn't intend for that...I will liberalize his diet and get him whole milk, large portions, and a regular dysphagia mechanically altered diet."

An end of the day meeting was held on 05/09/2023 at approximately 4:00 p.m.. Concerns were voiced regarding Resident #1's weight loss and lack of additional interventions since January.

On 05/10/2023 Resident #1 was observed eating breakfast, while the occupational therapist was in the room. the occupational therapist stated, "I am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 692	Continued From page 36	F 692		

recommending cups with lids for him...I also think he might benefit from a plate guard to help him eat." The breakfast tray card was observed and contained the following:
Regular Dysphagia Mechanically Altered Diet
Orange Juice: 4 ounces
Scrambled eggs: 3 ounces
Slivered Green Onions: 1 tablespoon
Pureed Buttered Biscuit
Grits: 9 ounces
Whole Milk: 8 ounces
Hot Coffee or Hot Tea: 6 ounces
Sausage Gravy: 4 ounces

It was observed that Resident #1 had eaten 100% of his breakfast, but did not have any milk on the tray. When asked if he was full, Resident #1 stated. "I don't want to be a pig....but I would like a cake or something sweet." Resident #1's CNA was notified and stated that she would get something. At approximately 8:35 a.m., the CNA came and reported that Resident #1 had eaten 2 cups of ice cream after breakfast.

At approximately 8:40 a.m., the nurse practitioner caring for Resident #1 was interviewed. When asked if she was aware of Resident#1's weight loss, the nurse practitioner stated, "I was made aware of that yesterday...I ordered labs on him, a TSH, Free T4, CBC, and CMP....he hasn't labs since January. They were fine then, but in light of his weight loss, I will repeat them and see where we need to go from there." When asked what she would have done if she had known about the weight loss sooner, the nurse practitioner stated, "I would have ordered the labs sooner...I can't address what I don't know about." When asked if the residents weights when rounding, the nurse practitioner stated,"No, I don't have time to review

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 37 every patient's weights when I come in...I rely on the nurses and the RD to tell me if there is a problem with those...no one mentioned anything about him to me until yesterday." The above information was discussed during an end of the day meeting on 05/10/2023. No further information was provided prior to the exit conference on 05/10/2023.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to administer oxygen as ordered by the physician for one of sixteen residents in the survey sample (Resident #24). The findings include: Oxygen was administered to Resident #24 at 4 lpm (liters per minute) when the physician's order required a rate of 2 lpm. Resident #24 was admitted to the facility with diagnoses that included chronic kidney disease,	F 695	F 695 1. Resident #24 is receiving Oxygen as ordered by the physician. 2. All residents are at risk for deficient practice related to not following physician order for oxygen. The DON or designee will review current residents receiving oxygen to ensure that they are receiving oxygen as ordered by the physician. 3. The DON or designee will educate Licensed Nursing staff on properly following orders to ensure that residents are receiving oxygen as ordered by the physician.	6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 38	F 695		

atrial fibrillation, atherosclerotic heart disease, hypertension, diabetes, COPD (chronic obstructive pulmonary disease), and anemia. The minimum data set (MDS) dated 3/28/23 assessed Resident #24 as cognitively intact.

On 5/9/23 at 10:20 a.m., Resident #24 was observed in bed with oxygen being administered at 4 lpm via a nasal cannula. Resident #24's oxygen was observed again on 5/9/23 at 2:11 p.m. running at 4 lpm.

Resident #24's clinical record documented a physician's order dated 4/12/23 for oxygen at 2 lpm via nasal cannula.

On 5/9/23 at 2:20 p.m., the licensed practical nurse (LPN #6) caring for Resident #24 was interviewed about the oxygen rate. LPN #6 stated, "I think it is supposed to be at 2 lpm." LPN #6 reviewed the clinical record and stated the order called for 2 lpm rate. LPN #6 stated that she had not checked the Resident #24's oxygen rate today.

On 5/9/23 at 2:28 p.m., accompanied by LPN #6, Resident #24's oxygen was observed running at 4 lpm. LPN #6 stated that she had not adjusted the oxygen rate to 4 lpm and that she did not know who increased the rate or when.

On 5/9/23 at 2:51 p.m., the unit manager (LPN #2) was interviewed about Resident #24's oxygen flow rate. LPN #2 stated that nurses were expected to check oxygen rates each shift and set the rate as ordered.

This finding was reviewed with the administrator, director of nursing and regional nurse consultant

4. The DON or designee will perform weekly audits x 4, then monthly x2 to ensure oxygen therapy is provided as ordered.
5. Results of the audits will be presented to QAPI committee for review and recommendation.
6. Completion date 6/23/2023
The ADMIN/DON is responsible for implementation of the plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 39 during a meeting on 5/9/23 at 4:15 p.m. No other information was presented prior to exit about the oxygen rate.	F 695		
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 and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess one of sixteen residents (Resident #4) for entrapment risks, attempt alternatives, or obtain informed consent prior to use of bed rails. The findings include:	F 700	F 700 1. A bed rail assessment and consent was completed for Resident #4 for the use of bed rails. 2. All residents utilizing bed rails are at risk for deficient practice related to the use of bed rails due to entrapment. The DON, or designee will review current	6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

(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 700	Continued From page 40 Resident #4, with multiple falls from the bed, had no assessment for bed rails, which were in use with bolster cushions, no documented attempts at alternatives to the rails and no informed consent from the resident's responsible party about risks/benefits of the bed rails. Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated 3/14/23 assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/8/23 at 2:05 p.m., Resident #4 was observed in bed, noting cushioned bolsters on each side of the resident, positioned between the resident and the bed rails, which were in the raised position. The bed rails were approximately ten inches in length. Resident #4 was observed again in bed on 5/8/23 at 2:50 p.m. and 3:43 p.m. with the bed rails in the raised position and bolster cushions on each side against the rails. Resident #4's clinical record documented a physician's order dated 2/9/23 for "Bilateral 1/8 Assist Bars for Bed Mobility." Resident #4's plan of care (revised 5/5/23) documented use of "Assist bars to bed to aide in turning and positioning." The assist bars had been on the care plan since 3/7/22. Added to the care plan on 3/21/23 was, "Bed bolsters PRN [as needed] to assist with activities of daily living and fall prevention."	F 700	residents with bed rails to ensure the need for the bed rail and that a bed rail assessment and consent was completed. 3. The DON or designee will educate Licensed Nursing staff on assessing the need, entrapment risks, attempt alternatives and the need to obtain consent prior to the use of bed rails. 4 -The DON, or designee will complete weekly audits x4, then monthly x2 of residents with bed rails to ensure that the bed rails are appropriate for the resident, a bed rail assessment was completed and consent obtained. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction	

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 41	F 700		

Resident #4's clinical record documented no current assessment of the bed rails for safety. The most recent bed rail safety assessment was dated 3/7/22 and documented that the rails were non-restrictive and aided the resident with turning and positioning in bed. The record documented no attempted alternatives to the rails and no informed consent from the Resident #4's responsible party regarding risks/benefits of bed rail use. The record documented no safety assessment of the bed rails with use of the bolster cushions.

Resident #4's clinical record documented falls from the bed on 1/7/23, 1/23/23, 2/19/23, 3/10/23, 3/12/23 3/20/23 and 5/2/23. In response to these falls, there had been no re-assessment of the Resident #4's bed rail use, no review of alternative interventions, and no assessment for safety of the bed rails used in combination with the bolster cushions.

On 5/9/23 at 2:45 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about the bed rails and bolster cushions. LPN #2 stated, "There was supposed to be a physician's order for positioning devices."

On 5/9/23 at 3:35 p.m., the maintenance director (other staff #9) was interviewed about Resident #4's bed/rails. The maintenance director stated he performed a safety assessment of all beds, mattresses and bed rails during April 2023. The maintenance director stated nursing was responsible for assessing residents and any positioning devices.

On 5/9/23 at 3:47 p.m., the director of nursing

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 700	Continued From page 42 (DON) was interviewed about a recent assessment of Resident #4's bed rail use or an assessment of the bed rails with the bolsters. The DON stated there was no recent bed rail assessment for Resident #4 with the last one completed on 3/7/22. The DON stated there was no assessment regarding the use of the bolsters with the bed rails. The facility's policy titled Device Assessment/Bed Safety (effective 11/1/19) documented, "The Device Assessment will be completed to provide documentation of the needs, and risk factors involved in the use of a restraint or device used by the patient...The assessment will also help to determine that all alternatives have been considered and that the least restrictive restraint or device is being used...The Device Assessment is used to provide documentation that the patient/responsible party has been informed of the purpose, benefits, and potential complications associated with the use of a device...The assessment is to be completed by a licensed nurse before initiation of any restraint or device. The assessment will be reviewed and revised quarterly, annually, and with any significant change...The specific type and reason for use of the device or restraint will be documented on the Device Assessment..." This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information regarding assessment of Resident #4's bed rails use.	F 700		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 43 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure medications were properly dated on two of two medication carts. Undated multi-dose medication bottles were observed in the East Unit medication cart and the Central Unit medication cart. The findings include: 1. At 3:20 p.m. on 5/9/2023, an observation of the East Unit medication cart was conducted in	F 761	F 761 1-All OTC medications, vials, liquid supplements stored on medication carts and medication room /refrigerators are labeled correctly for date opened and expiration dates. 2-All residents receiving medications are at risk for deficient practice related to inadequate labeling of medications. The DON, or designee will inspect the medication carts and the medication room, and refrigerators for any	

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATION CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 761	Continued From page 44 the presence of RN # 2 (Registered Nurse). The medication cart included the following medications: A 32 oz (ounce) bottle of Milk of Magnesia (MOM) appeared to be nearly empty, but had no open date. A 16oz bottle of Geri Tussin Guaifenessin oral solution, with a punctured inner seal, but had no open date. A 16 oz bottle of Pro Stat, Wild Cherry flavor, that appeared to be nearly empty, but had no open date. Asked about expiration dates for the multi-use bottles of pills, RN # 2 said, "I'm not sure." RN # 2 then turned to LPN # 2 (Licensed Practical Nurse), who was standing nearby, and asked what the open date meant on the multi-use bottles of pills. "Oh, that's just the date we opened it. Everything has to have an open date," LPN # 2 said. Calling her attention to the open and nearly empty bottle of MOM, LPN # 2 said, "Oh, this has to be discarded. No date." LPN # 2 then discarded the bottle in the trash. When asked what the expiration date would be for the mediction bottles, LPN # 2 said, "I guess we just use the expiration date already on the bottle. Wait, I don't want to tell you the wrong thing." LPN # 2 walked away but did not return to offer any further explanation or clarification. Pointing to the bottle of Pro Sat, RN #2 was asked when it had been opened. Picking up the bottle and turning it around to examine all surfaces, RN #2 shrugged and stated, "I don't know. There's no open date on it. I guess I have to throw it in the trash." RN #2 also threw away the bottle of Geri Tussin when she was unable to find an open	F 761	medications not labeled appropriately. 3-The DON, or designee will educate Licensed Nurses on proper labeling of medications in the medication carts and medication room, and medication refrigerators. 4-The DON, or designee will complete weekly inspections of the medication carts and medication room refrigerators x 4, then monthly x2 to ensure that medications are labeled properly. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 45	F 761		

date.

2. At 3:50 p.m. on 5/9/2023, an observation of the Central Unit medication cart was conducted in the presence of LPN # 5. The medication cart included the following medications:

A 16 oz bottle of Lactulose was half-full and open, but had no open date or expiration sticker
A 414 ml (milliliter) bottle of Sucralfate was open, half full, but had no open date or expiration sticker.
A 16 oz bottle of MOM, that was nearly empty, but had no open date or beyond use date sticker.
A bottle of Vitamin B12 500mg 100 tab bottle had an open date of 8/24/22, but no expiration sticker.

The remaining medications in the cart had an open date, as well as an expiration sticker with a "Beyond Use Date." Asked what the "Beyond Use Date" meant, LPN # 5 said, "I'm not sure. I guess it means that you throw it away after that date." Concerning the undated bottle of MOM, LPN # 5 said, "Yes, it should have been dated when it was opened, but I'll throw that away now. Anything without an open date should be thrown away." After confirming that the bottles of MOM and Sucralfate were also opened and undated, LPN #5 discarded them.

At 10:00 a.m. on 5/10/2023, LPN # 4 was asked her understanding of the "Beyond Use Date." "Meds [Medications] should be discarded on this date. I mean, it's ok to use it on that date, but you can't use it afterwards," LPN # 4 said. When asked how the discard date is identified if there is no "Beyond Use Date", LPN #4 stated, "You go by the manufacturer's date." LPN #4 pointed to the manufacturer's expiration date of 4/24 on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 46 Vitamin B12 bottle. At 10:22 a.m. on 5/10/2023, the Director of Nursing (DON) was shown the open bottle of Prostat from the East Unit medication cart. When asked what should be done with the bottle, the DON said, "I would throw it away. It wasn't dated. You don't know when it was opened." Review of the facility's Storage of Medications policy noted the following: "III. Expiration Dating (Beyond-Use Dating) 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a 'date opened' sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating." The findings were discussed at a 10:30 a.m. meeting on 5/10/2023 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F 761		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 791	Continued From page 47 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide dental services to one of 16 residents, Resident	F 791	F 791 1-Resident #1 has been scheduled to see a Dentist.	

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 791	Continued From page 48 #1. Findings were: Resident #1 was admitted to the facility with the following diagnoses, including but not limited to: encephalopathy, diabetes mellitus, COPD (chronic obstructive pulmonary disease), major depressive disorder, vascular dementia, hypertension, and hypothyroidism. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/26/2023, assessed Resident #1 as moderately impaired with a cognitive summary score of "09" out of 15. During initial tour of the facility on 05/08/2023 at approximately 12:15 p.m., Resident #1 was observed in his room. While speaking, Resident #1's mouth was observed with no front upper or lower teeth. On 05/09/2023 at approximately 11:00 a.m., Resident #1 was about having a partial plate or dentures at the facility. Resident #1 stated, "When I grew up, we didn't have much money, I still don't. These are all the teeth I have." Resident #1 opened to reveal approximately four teeth on the top row, two on each side, and four teeth on the bottom row, two on each side. When asked about the presence of pain with eating, Resident #1 stated, "No, I guess you just get use to it." When asked about desire to see a dentist, Resident #1stated, "I don't think I have the money for that, but teeth would be good." The clinical record was reviewed at approximately 11:15 a.m. The physician order section contained an order for "Dental Consult PRN (as needed)."	F 791	2-All residents are at risk for deficient practice related to the possible need for Dental services. The Administrator, or designee will determine if any current residents require or are requesting Dental services and assist with Dental service arrangements. 3-The Administrator, or designee will educate the Interdisciplinary Team and Licensed Nursing staff on Dental services requirements for the residents and include education on the process of providing Dental services for the residents. 4-The Discharge Planner, or designee will assess the need for Dental services for residents weekly x4 then monthly x2, then as needed to ensure that the Dental service is provided for those residents. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 791	Continued From page 49	F 791		

There were no progress notes or office visit notes observed in the record from a dentist.

At approximately 11:30 a.m., the administrator was asked if the social worker was available for interview. The Administrtor stated, "We don't have one right now, we are dividing up the duties." When asked who would be responsible for referring residents to a dentist, the Administrator stated, "We have a dentist that comes here...I believe he was here last month." When asked if Resident #1 had been seen by a dentist, the Administrator stated he didn't know but would check.

The above information was discussed during an end of the day meeting with the DON (director of nursing), the administrator, and the regional nurse consultant on 05/09/2023 at approximately 4:00 p.m.

On 05/10/2023 the unit manager, LPN (Licensed practical nurse) #2 brought information to the conference room and stated, "We ordered a dental consult...here are his oral assessments that we have done." The documentation presented three "Oral Assessments" completed on 12/28/2022, 01/24/2023, 04/26/2023. All three assessments documented that there were "no issues" with Resident #1's oral health. When asked if she thought the assessments were accurate, LPN #2 stated, "I would have marked either 'no natural teeth or tooth fragments' or 'Obvious or likely cavity or broken natural teeth'...I did a dental exam on [Resident #1] last night... [Resident #1] doesn't have very many teeth, but said the only thing that bothers him when eating is the tremors he has in his hands. [Resident #1] did agree to a dental consult, so we have him on

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 791	Continued From page 50 the list." No further information was obtained prior to the exit conference on 05/10/2023.	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to store, serve, and prepare food in a sanitary manner in the main kitchen. Findings were: Initial tour of the facility kitchen was conducted on 05/08/2023 at approximately 11:15 a.m., with the DM (dietary manager-other staff #1). Observed in the refrigerator next to the tray line was a	F 812	F 812 1. All findings related to storage, preparation, distribution and handling of food were immediately corrected. 2. At risk of deficient practice related to food procurement/storage/preparation/service concerns. The Dietary Manager or designee will complete a kitchen inspection to ensure equipment for food	6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 51 plastic bag. When asked what was in the bag, the DM stated, "Her lunch", nodding towards the staff member plating food on the tray line. Also observed in the refrigerator were canned sodas. When asked if those belonged to residents, the DM stated, "No, employees...they shouldn't be in here and the lunch shouldn't be either." The bins storing flour, sugar, and thickening were observed. Scoops for each bin were to be stored inside the bin, affixed to the top, away from the food ingredients. The scoop for the sugar was observed out of place and laying down in the stored sugar. The can opener which was affixed to a table in the kitchen, was observed with dark, dried debris on the blade area that punctures the cans. When asked how often the can opener was washed, the DM stated, "About three times a week or as needed." A rack in the kitchen was identified as containing stacked, dried, and clean pans, with a smaller rack of bowls stationed beside it. The DM was asked to separate the pans to ascertain if they were clean on the inside. Two quarter-sized pans and one full-size pan were observed to be wet nested with water droplets on the interiors of the pans. Three white bowls were observed with dried debris on the inside. All of the dishes identified as compromised were removed from the area by the DM, as she stated, "They are suppose to be clean and dry before they are put over here." The above information was discussed with the DON (director of nursing), the administrator, and the regional nurse consultant during an end of the	F 812	serving and preparation and food is properly stored. 3. The Administrator or designee will educate the dietary team on proper and sanitary practices for the preparation/service/storage of food. 4. The Dietary Manager or designee will perform weekly audits x4 weeks, then monthly x2 of the kitchen inspection to ensure equipment for food serving and preparation and food is properly stored. 5. Results of the audits will be presented to the QAPI Committee for review and recommendation. 6. Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 812	Continued From page 52 day meeting on 05/09/2023 at approximately 4:00 p.m. No further information was obtained prior to the exit conference on 05/10/2023.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (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;	F 842		6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 53 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for three of sixteen residents in the survey sample (Residents #24,	F 842	F 842 1-The clinical record for Resident #24 has been updated and the order for precautions was discontinued. Resident	

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F 842	Continued From page 54 #30 and #41). The findings include: 1. Resident #24's clinical record inaccurately documented a physician's order for enhanced barrier precautions when the precautions had been discontinued since 4/20/23. Resident #24 was admitted to the facility with diagnoses that included chronic kidney disease, atrial fibrillation, atherosclerotic heart disease, hypertension, diabetes, COPD (chronic obstructive pulmonary disease), and anemia. The minimum data set (MDS) dated 3/28/23 assessed Resident #24 as cognitively intact. Resident #24's clinical record documented a current physician's order dated 3/29/23 for "Enhanced Barrier Precautions" for infection control. The clinical record documented the precautions were implemented due to the resident's PICC (peripherally inserted central catheter). The clinical record documented the PICC was discontinued on 4/20/23. On 5/9/23 at 2:52 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about Resident #24. LPN #2 stated Resident #24 was on enhanced barrier precautions because of the PICC. LPN #2 stated no order had been entered to discontinue the precautions. LPN #2 stated the precautions should have been discontinued when the PICC was removed. 2. Resident #30's clinical record inaccurately documented a physician's order for enhanced barrier precautions when the precautions had	F 842	#30 and resident #41 were discharged from the facility. 2-All residents are at risk for deficient practice related to incomplete and inaccurate clinical records. The DON, or designee will review current residents no longer on precautions to ensure that the discontinued need for precautions is reflected accurately in the clinical record for the resident. 3-The DON, or designee will educate Licensed Nurses on proper procedures for discontinuing precaution orders when the resident no longer requires precautions. 4-The DON, or designee will complete weekly audits x4, then monthly x2 of residents no longer requiring precautions to ensure that the precaution orders were discontinued from the clinical record appropriately. 5 -Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 842	Continued From page 55	F 842		

been discontinued since 4/26/23.

Resident #30 was admitted to the facility with diagnoses that included dislocated hip, femur fracture, atherosclerotic heart disease, major depressive disorder, atrial fibrillation, and Alzheimer's dementia. The minimum data set (MDS) dated 2/4/23 assessed Resident #30 with severely impaired cognitive skills.

Resident #30's clinical record documented a current physician's order dated 3/7/23 for "Enhanced Barrier Precautions" for infection control. The clinical record documented the infection precautions were ordered due to a diagnosed urinary tract infection.

On 5/9/23 at 2:32 p.m., the licensed practical nurse (LPN #6) caring for Resident #30 was interviewed about any precautions. LPN #6 stated that Resident #30 was not currently on any type of infection control precautions. LPN #6 stated it was possible the order was not discontinued timely.

On 5/9/23 at 3:55 p.m., the unit manager (LPN #2) was interviewed about Resident #30. LPN #2 stated Resident #30 had a urinary tract infection and the infection precautions should have been discontinued when the infection cleared. LPN #2 stated the infection cleared on 4/16/23 and the precautions should have been removed ten days after that on 4/26/23. LPN #2 stated that no order was entered to discontinue the precautions after the infection cleared.

3. Resident #41's clinical record inaccurately documented a current physician's order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 56	F 842		

enhanced barrier precautions when the catheter for which is was ordered had been discontinued since 3/22/23.

Resident #41 was admitted to the facility with diagnoses that included vertebra compression fractures, atrial fibrillation, sepsis, pneumonitis, urinary tract infection, atherosclerotic heart disease, anxiety, asthma, congestive heart failure, urine retention, and kidney failure. The minimum data set (MDS) dated 2/27/23 assessed Resident #41 as cognitively intact.

Resident #41's clinical record documented a current physician's order dated 3/7/23 for "Enhanced Barrier Precautions" for infection control. The clinical record documented the resident previously had a Foley urinary catheter and had been placed on enhanced barrier precautions when providing catheter care. The clinical record documented the catheter was discontinued on 3/22/23.

On 5/8/23 at 3:14 p.m., the registered nurse (RN #5) caring for Resident #41 was interviewed about infection control precautions. RN #5 stated Resident #41 did not currently require any type of infection control precautions and had not recently been on enhanced barrier precautions.

On 5/8/23 at 3:20 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about order for enhanced barrier precautions. LPN #2 stated that Resident #41 was ordered precautions due to a urinary catheter. LPN #2 reviewed the clinical record and stated the catheter was discontinued on 3/22/23 but no order was entered to discontinue the infection control precautions. LPN #2 stated that an order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 842	Continued From page 57 should have been entered to discontinue the precautions when the catheter was discontinued. On 5/9/23 at 9:45 a.m., the registered nurse infection preventionist (RN #3) was interviewed about current orders for Residents #24, #30 and #41 for infection precautions. RN #3 stated she expected nursing to obtain an order to discontinue the precautions when the devices and/or infections were discontinued and/or cleared. These findings were reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. No further information was presented prior to exit about the inaccurate physician orders.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 58 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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	495188	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 59 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility failed to ensure infection control practices were followed during the treatment of a pressure ulcer for one of 16 resident's, Resident #6, and failed to ensure enhanced precautions were ordered for one of 16 Resident's, Resident #257. The Findings Include: 1. During a wound dressing change for Resident #6, the facility nurse failed to follow hand hygiene practices consistent with accepted standards of practice. Diagnoses for Resident #6 included; Hemiplegia, contractures, bursa right elbow, dementia, and pressure ulcers. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/30/23. Resident #6 was assessed with long and short-term memory problems and severely cognitively impaired. On 5/8/23 Resident #6's clinical record was reviewed. An active physician's order read: "Right lateral foot: Cleanse with wound cleanser,	F 880	F 880 1-. Resident # 6 is receiving wound care per policy and CDC standards for infection control. Resident #257 no longer requires precautions, and the clinical record was updated appropriately. 2- The facility is at risk for deficient practice related to infection control practices not being followed . The DON or designee will review all residents requiring precautions and ensure that precaution orders are reflected in the clinical record correctly. The Staff Development Coordinator, or designee will observe all Licensed nursing staff providing wound care to ensure that infection control practices are followed appropriately. 3- The DON or designee will provide in-service on Wound care policies and procedures to include proper infection control practices when providing wound care and the proper procedure for obtaining orders for those residents requiring precautions. 4- The DON or designee will perform observation of 2 nurses performing wound care audits weekly x4, then monthly x2 to ensure that proper infection control practices are being followed with wound	

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F 880	Continued From page 60 apply collagen particles and calcium alginate, wrap with kerlix and secure with tape." Review of Resident #6's most recent skin assessment dated 5/8/23 documented Resident #6 had a stage 4 pressure ulcer to the right foot. On 5/09/23 at 10:31 AM during observation of a dressing change to Resident #6's right foot (with license practical nurse, LPN #4) the following steps occurred: LPN #4 washed hands and prepped the an area on a table and washed hands again, removed dressing, washed hands and applied cleaned gloves, cleaned the wound using a cleanser and gauze (did not remove her gloves, wash hands or apply clean gloves) poured the collagen particles into her gloved hand and placed the particles directly onto the wound with her gloved hand, applied calcium alginate then wrapped the wound. After the observation, LPN #4 was asked about washing hands after cleaning the wound and putting on clean gloves before applying the collegen particles, LPN #4 verbalized that she should have considered doing that. On 5/09/23 at 11:12 AM the above finding was presented to the infection control nurse (registered nurse, RN #3), RN #3 said she would expect the nurse to wash hands and get new gloves after cleaning the wound and before applying the collagen. On 5/09/23 at 4:18 PM the above information was presented to the administrator, director of nursing, and regional nurse. The regional nurse verbalized that the nurse should have washed her hands and got new gloves after cleaning the	F 880	care. The Staff Development Coordinator, or designee will complete weekly audits of residents requiring precautions to ensure that the order is obtained and documented in the clinical record appropriately. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. 6-Completion date 6/23/2023 The Admin/DON are responsible for implementation of the plan of correction.	

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F 880	Continued From page 61	F 880		

wound.

No other information was provided prior to exit conference on 5/10/23.

2. The facility did not have enhanced precautions ordered for a supra pubic catheter for Resident #257. Resident #257 was admitted to the facility with the following diagnoses including, but not limited to, hypertension, pulmonary edema, protein-calorie malnutrition, anemia, pneumonia, urethral stricture, and pseudomonas pneumonia.

Due to his recent admission, no MDS (minimum data set) information was available. When interviewed regarding his care at the facility, Resident #257 answered questions appropriately.

During initial tour of the facility on 05/08/2023 at approximately 12:15 p.m., Resident #257 was observed lying supine on his bed. His pajama top was not pulled all the way down and a suprapubic catheter was observed. No signage was observed on his door indicating he was on any type of isolation precautions, nor was there an isolation cart at his door.

The unit manager, LPN (licensed practical nurse) #2 was asked at approximately 12:30 p.m., which residents were on any type of isolation precautions. Resident #257 was not named.

Throughout the day on 05/08/2023, Resident #257's room was observed and no isolation precautions were posted.

The clinical record was reviewed on 05/08/2023

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F 880	Continued From page 62	F 880		

at approximately 2:30 p.m. There were no physician orders indicating that Resident #257 should be on any type of isolation precautions. There were no entries in the care plan regarding the need for any isolation precautions.

On 05/09/2023, at approximately 8:00 a.m.,, LPN #1 was interviewed regarding which residents were on isolation on the unit. Another resident on the unit with a Foley catheter was observed with signage on the tesident's doorway for "Enhanced Precautions." LPN #1 was observed donning a gown and gloves to enter that resident's room. When asked why the resident was on Enhanced Precautions, LPN #1 stated, "Because she has a Foley catheter." When asked why Resident #257 was not on the same precautions given the suprapubic catheter, LPN #1 stated, "I don't know."

At approximately 9:00 a.m., a sign was observed on Resident #257's door indicating he was on "Enhanced Precautions" and a isolation cart was outside of his room.

At approximately 10:00 a.m., the infection preventionist, RN (registered nurse) #3 was interviewed. When asked why Resident #257 was placed on enhanced precautions, RN #3 stated, "[Resident #257] has a suprapubic catheter." When asked why, since the catheter was present at the time of admission, was he just being now being put on isolation precautions, RN #1 stated, "I think [Resident #257] came in Friday evening. I wasn't here and I wasn't here over the weekend....[Resident #257] should have been on precautions from the time of admission...I'm the one who puts the signage up." When asked if the nurses on the unit could put the signage up, RN

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F 880	Continued From page 63	F 880		

#3 stated, "Yes." When asked if the nurses were aware that residents with catheters should be placed on enhanced precautions, RN #3 stated, "Yes, they are aware."

At approximately 10:30 a.m., RN #3 presented an Inservice/Education Record from 03/21/2023 verifying that nursing staff had received education on Enhanced Precautions. Attached to the sign-in sheet for the education was the facility policy, "Enhanced Barrier Precautions" which contained the following information:
"Indicated for patients: ...with indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy, etc.) regardless of MDRO (multi-drug resistant organism) colonization/infection status..."

The above information was discussed during an end of day meeting was held on 05/09/2023 at approximately 4:00 p.m. with the DON (Director of Nursing), the administrator, and the regional nurse consultant.

No further information was obtained prior to the exit conference on 05/10/2023.