STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495123	A. BUILDING _____ B. WING _____	R-C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	905 COUSINS AVENUE HOPEWELL, VA 23860

(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 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the standard survey, conducted 7/9/23 through 7/14/23, was conducted 10/30/23 through 11/03/23. The first revisit to the standard survey was conducted 8/29/23 through 8/30/23. An extended survey was conducted 10/31/23 through 11/03/23. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. On 10/31/23, Immediate Jeopardy was identified in the area of Pressure Ulcers at a Scope and Severity Level 4, isolated which constituted Substandard Quality of Care. After accepting the plan for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level 3, isolated. On 11/02/23, Immediate Jeopardy was identified in the area of Accidents/Hazards at a Scope and Severity Level 4, isolated which constituted Substandard Quality of Care. After accepting the plan for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level 2, isolated. One complaint (VA00059895-substantiated with deficiency) was investigated during the survey. The census in this 130 certified bed facility was 112 at the time of the survey. The survey sample consisted of 32 resident reviews.	{F 000}		
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		12/18/23

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

Electronically Signed | 11/27/2023

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F 580 SS=D	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 2 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation the facility staff failed to immediately inform the resident representative(s) when there was a significant change in the Resident's condition for 2 Residents (#201, #208) in a survey sample of 32 Residents. The findings included: 1. For Resident #201 the facility staff failed to notify the Resident's Power of Attorney of the Resident being sent out to the emergency room (ER). On 10/30/23 a review of the clinical record was conducted, and it was found that on 8/26/23 Resident #201 was send to the ER with maggots in his infected venous stasis ulcer. A review of the clinical record revealed that on the face sheet the Resident's daughter was listed as his Power of Attorney (POA) for medical and financial matters. On 10/31/23 a review of the Clinical Record revealed that Resident #201 had an E-Interact Change in Condition form dated 8/26/23 that read	F 580	The facility sets forth the following plan of correction to remain in compliance with all federal and 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 deficiencies cited have been or will be corrected by the date or dates indicated. F580 1. Resident #201 no longer resides at the facility. Resident #208 no longer resides at the facility. 2. Residents discharged to the hospital over the past 30 days will be reviewed to ensure that the Resident representative or POA was notified of the discharge. Resident representative or POA will be notified of the discharge upon completion of the review if not previously notified. 3. All nurses will be educated on documentation of Resident representative/POA notification when transferring a Resident to the hospital at	

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F 580	Continued From page 3 as follows: Page 3 "Section C- Resident Representative Notification" "Name of family/resident representative notified: Resident is own POA." On 10/31/23 at 3:00 PM an interview was conducted with RN B (Registered Nurse-B) who stated that if a Resident has next of kin, POA or emergency contact information in the chart they are supposed to inform that person when there is a change in the condition of the Resident. When asked if this included transporting to the emergency room, RN B stated "If the Resident is in bad shape and going to a hospital, we might inform them after they have left via 911 however it depends on how urgent it is. If there is time, we call the Responsible Party first but if not, we call immediately after they leave in the Ambulance." On 11/3/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #208, the facility staff failed to notify the Resident's Representative, of the Resident's transfer to the hospital. On 10/30/23, a clinical record review was conducted of Resident #208's chart. This review revealed that Resident #208, was transferred to the hospital on 10/23/23. Review of Resident #208's progress notes revealed an entry from the medical provider on 10/18/23 at 1 PM, that read, "Resident is a (age/gender) who is seen today in follow-up for 2 episodes of black vomit. Per nursing resident had 2 episodes this morning of black coffee-ground	F 580	time of the transfer. 4. The Unit Managers will review discharges to the hospital weekly times 4 and monthly times 2 to ensure that Resident representative/POA notification is documented. Results of the reviews will be presented to the QA committee monthly times 2. 5. Completion date: December 18, 2023	

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F 580	Continued From page 4	F 580		

emesis. Upon examination resident is in no acute distress but complains of nausea and epigastric discomfort... Resident to be sent to the emergency room for evaluation for hematemesis".

There was no evidence in the clinical record that indicated the Resident's family member, who according to the Resident's face sheet was listed as "Responsible Party, Emergency Contact #1, POA- [power of attorney] Financial, and POA-medical", was made aware of the Resident being sent to the hospital.

There was a progress note entry by the social worker on 10/23/23 at 16:28 (4:28 PM), that read, "This resident's brother, [name of brother redacted] stated that he called his brother's room at 12:00PM and the person who answered the phone stated that his brother had gone out to the hospital. He said he called here at 4:00PM and spoke to the DON [Director of Nursing]. He called and asked this SW [social worker] why he was not called. This SW spoke to the DON, and she spoke to his nurse. The DON stated that the nurse said she forgot to call the brother to inform him that his brother had been sent out to the hospital. This SW called the brother back and he stated that the DON had just called him and explained the reason why his brother went out and why he was not called. The brother asked this SW to writer a formal complaint. This SW filled out a complaint/grievance report".

On 11/3/23, the survey team obtained a copy of the "Complaint/Grievance Report" that was written on 10/23/23, with regards to Resident #208. It read, "Resident's brother [name redacted] asked why he was not called when his

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F 580	Continued From page 5 brother was sent out to the hospital". The "Documentation of the Investigation" portion of the form read, "[Director of Nursing's name redacted] DON called Mr. [brother's name redacted] and let him know that the nurse forgot to call him". A review of the facility policy titled; "Significant Change of Condition" was conducted. This policy read, "All staff members shall communicate any information about patient status change to appropriate licensed personnel immediately upon observation. Procedure: 1. The patient's change of condition shall be reported immediately to a licensed nurse... 4. Responsible party will also be notified of a change of condition... 9. Notification of responsible party shall be documented in the Progress Notes including time and name of person informed...". No further information was provided.	F 580		
{F 623} SS=E	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	{F 623}		12/18/23

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

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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{F 623}	Continued From page 7	{F 623}		

completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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{F 623}	Continued From page 8 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to issue a notice in writing, at the time of transfer indicating the reason of transfer and appeal rights, for two Residents (Resident #208 and 213) in a sample of 3 Residents reviewed. The findings included: On 10/30/23, a sample of 3 recent unplanned discharges were selected for review. The clinical record for each Resident was reviewed and revealed the following: 1. For Resident #208, the facility staff failed to issue a notice of transfer/discharge to the Resident and/or Resident Representative, at the time of the transfer. On 10/30/23, a clinical record review was conducted. This review revealed that Resident #208, who was transferred to the hospital on 10/23/23, the "Notice of Transfer/Discharge" was not provided to the Resident and/or Resident responsible party at the time of transfer. The form indicated that it was mailed to the responsible party on 10/23/23. The section "E. Notice was hand delivered to:" was blank. Review of Resident #208's progress notes revealed an entry from the medical provider on 10/23/23 at 1 PM, that read, "Resident is a (age/gender) who is seen today in follow-up for 2 episodes of black vomit. Per nursing resident had 2 episodes this morning of black coffee-ground emesis. Upon examination resident is in no acute	{F 623}	F623 1. Resident #208 no longer resides at the facility. Resident #213□s responsible party was notified of the transfer by mail and has had no further transfers. 2. All Residents who are transferred or discharged from the facility are at risk. Residents transferred or discharged over the past 30 days will be reviewed to ensure that timely notice was provided. Residents who did not receive a timely notice will be notified that a timely notice was not issued. 3. The SW/DP will be educated by the Administrator/designee on timely provision of written notice of discharge/transfer to include the reason for the transfer or discharge and documentation of the notice at time of transfer. All nurses will be educated by the Administrator/designee on timely provision of written notice of discharge/transfer at time of transfer when SW/DP is not available. 4. The Administrator/designee will review provision and documentation of the written notice of discharge/transfer weekly times 4 and monthly times 2. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. December 18, 2023	

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distress but complains of nausea and epigastric discomfort... Resident to be sent to the emergency room for evaluation for hematemesis".

There was no evidence in the clinical record that indicated a transfer/discharge notice was provided at the time of transfer, which would have given the details of why they were being transferred, location where they were being transferred to, or their appeal rights. It was mailed to the family member, which would not have been received until the following day, at the earliest.

2. For Resident #213, the transfer/discharge notice was not provided at the time of transfer/discharge.

On 10/30/23, a clinical record review was conducted. This review revealed that Resident #213 was sent to the hospital on 10/20/23. The progress notes read, "10/20/2023 at 16:50 (4:50 PM), Resident has a HGB [hemoglobin] of 5.6. Dr. [name of physician redacted] was notified. Send to ER/EVAL and possible blood transfusion. Resident notified as well as RP [responsible party]. O/2 [oxygen] sats-84%. 911 was called and transferred to [hospital name redacted]".

Review of the "VA- Notice of Transfer/Discharge" form revealed that section B. read, "Date of transfer/discharge: 10/20/2023". Section E read, "Notice was hand delivered to: " was blank and F1. stated, "Date notice was mailed: 10/23/2023".

On 10/30/23 at 1:46 PM, an interview was conducted with Employee E, the social worker. Employee E confirmed that she is responsible for

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issuing the transfer/discharge notice. The social worker was asked how this is done and she said, "I run a report every day, to see who was discharged and I mail the notice to the family."

During the above interview, the social worker accessed and confirmed that neither of the Residents, nor their family were provided the transfer/discharge notice at the time of discharge, she stated, "they don't let us know when they are going out, I have to run a report daily or find out in the stand-up meeting". When asked what happens in the evenings or weekends when the social work department is not staffed, she said, it waits until they return.

Review of the facility policy titled; "Notice of Transfer/Discharge" was conducted. Excerpts from this policy read, "... 4. Provide proper advance written notification of the transfer/discharge to the patient and family member/legal representative utilizing the [company name initials redacted] Notice of Transfer/Discharge form. Under federal and state law: i. If a transfer/discharge is voluntary a discharge can be coordinated as soon as practicable. ii. If a transfer/discharge is involuntary and for the following reasons, notification shall be made as soon as reasonably possible: 1) The patient's welfare and needs cannot be met in the Center...".

On 10/30/23, during the end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.

No further information was provided.

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{F 645}	Continued From page 11	{F 645}		
{F 645} SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide	{F 645}		12/18/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 645}	Continued From page 12 for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to obtain and/or complete a Preadmission screening (PASRR) timely for one Resident, (Resident #204) in a survey sample of 3 Resident's reviewed. The findings included:	{F 645}	F645 1. Resident #204□s PASARR was completed on 10/16/23. 2. All Residents admitted to the facility with mental disorder or intellectual disability are at risk. Those admitted within the past 30 days will be reviewed to	

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{F 645}	Continued From page 13 For Resident #204, who was admitted to the facility on 10/14/23, the facility staff failed to obtain/or complete a Pre-Admission Screening and Resident Review (PASRR), to determine if the Resident had a mental disorder or intellectual disability. On 10/30/23, a clinical record review was conducted. This review indicated that Resident #204 was admitted to the facility on 10/14/23. Under the "Documents" tab of the record there was a PASRR, that had been completed on 10/16/23. Review of the PASRR form, revealed the following statement(s) on the top of the form. It read, "This form, or the DMAS-95 for Medicaid members, must be completed for ALL individuals seeking a Nursing Facility admission. The form must be completed PRIOR to a Nursing Facility admission by the Staff assigned to conduct Level I Screening...". On 10/31/23 at 1:00 PM, an interview was conducted with Employee F, the social work assistant. Employee F was the employee that signed the PASRR as the person completing the assessment for Resident #204 on 10/16/23. Employee F was asked about the purpose of the PASRR and timing. Employee F said, "It is to evaluate and see if a Resident coming in needs further treatment if they have serious mental illness or disability". When asked about the timing of the PASRR assessment, Employee F said, "They are supposed to be done as soon as they come in, within a few days of them coming here."	{F 645}	ensure that a PASARR was completed and is present in the electronic medical record. 3. The SW/DP will be educated by the Administrator on timely completion of a PASARR when the Resident is admitted without a completed PASARR from the hospital and scanning of the PASARR into the electronic medical record. The Administrator/designee will educate the Admission Coordinator on completion of the PASARR when necessary to ensure that the PASARR is completed in a timely manner. 4. The Administrator/designee will review the medical record of newly admitted Residents to ensure that the PASARR is available on a weekly basis time 4 and monthly times 2. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 645}	Continued From page 14	{F 645}		

Employee F accessed the clinical record of Resident #204 and was asked to explain the timing of the PASRR for that Resident. Employee F said, "I think he was admitted on a weekend, so I did it on the 16th when I came in." Employee F looked at a calendar and confirmed, that Resident #204 was admitted on a Saturday and therefore the PASRR was not completed prior to admission.

The facility policy titled, "Level I PASRR- Virginia," with an effective date of 1/6/20, was requested and received. This policy read, "Policy: Prior to the arrival of a planned admission the Social Work and Discharge Planner will collaborate with the Admissions Director to preview the transferring hospital's Level I PASRR (Level I Screening for Mental Illness, Intellectual Disability, or Related Conditions) and/or initiate completion of the Level I PASRR if not completed by the transferring hospital. Procedure: 1. The purpose of the Level I PASRR is to predetermine if the transferring patient meets SNF/NF criteria and to screen the patient for indicators of serious mental illness, mental retardation, developmental disabilities or related conditions prior to being admitted in the SNF/NF Center, as required by Federal Regulation. Admissions requests the PASRR Level I from transferring hospitals, regardless of payer source, prior to the patient's discharge to the Center".

"2. Prior to admission, review the transferring hospital's preadmission paperwork to determine if the transferring hospital has completed a Level I PASRR. If the Level I PASRR is missing from the preadmission paperwork, collaborate with admissions to determine if/why the admitting patient is exempt from the hospital screening in

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{F 645}	Continued From page 15 order to initiate completion of the Level I PASRR internally... a. In the absence of a Social Work and Discharge Planner, the Administrator will appoint a designee who has access to the relevant medical information necessary to conduct the Level I PASSR [sic]". On 10/31/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	{F 645}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	{F 657}		12/18/23

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{F 657}	Continued From page 16 (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 interview, clinical record review and facility documentation the facility staff failed to review and revise the care plan for two Residents, (#214 & #223) in a survey sample of 32 Residents. The findings included: 1. For Resident # 214 the facility staff failed to revise care plan to reflect the removal of PICC (Peripherally Inserted Central Catheter) line inserted in 7/4/23 and put a new entry for the PICC line inserted on 10/2/23, they also did not put interventions to measure the external portion of the PICC line or the circumference of the upper arm. On 10/31/23 at approximately 11:00 AM observation was made of Resident #214 with a PICC line in her upper right arm. During clinical record review on 11/1/23 it was noted that the Resident had the following entry for PICC line: FOCUS: the resident has a PICC Line venous access, left arm Created on: 07/05/2023 Revision on: 10/03/2023. GOAL: the resident will not have complications from their PICC line access site thru review period Created	{F 657}	F657 1. Resident #214□s care plan was revised to remove use of the PICC line. Resident #223□s care plan was revised to reflect current use of side rails. 2. All Residents are at risk. Residents with PICC lines and those with side rails will be reviewed to ensure that the care plan accurately reflects the Resident□s use of PICC line or side rails. 3. All Nurses will be educated by the DON/designee on revision of the care plan to reflect current Resident needs. 4. The UM/designee will review Residents with PICC lines or with changes in use of bed rails on a weekly basis time 4 and monthly basis times 2 to ensure that the care plan accurately reflects Resident needs. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 657}	Continued From page 17 on: 07/05/2023 Revision on: 10/03/2023 Target Date: 10/07/2023. INTERVENTIONS: CXE to confirm PICC line placement Created on: 10/03/2023. Dressing change per order Created on: 07/05/2023 Revision on: 10/03/2023. Flush per order Created on: 07/05/2023 Revision on: 10/03/2023. Notify MD as indicated Created on: 07/05/2023 Revision on: 10/03/2023. Observe PICC line access site for signs and symptoms of redness, swelling, infection, displacement or infiltration Created on: 07/05/2023 Revision on: 10/03/2023\ The entry in the care plan refers to PICC LINE in LEFT arm that is from July 2023 the PICC line inserted on 10/2/23 was in the RIGHT upper arm. The Interventions do not include measuring the external PICC line or arm circumference. A review of Policy #2602 entitled "Care Planning," revealed excerpts that read as follows: "Procedure -"6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment." On 11/1/23 at approximately 4:30 p.m. an interview was conducted with the Corporate Nurse Consultant who was asked if the care plan should have been reviewed and revised when the PICC line inserted in July was discontinued, she stated that it should have been resolved and a new Focus started when the new PICC line was inserted on 10/2/23.	{F 657}		

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{F 657}	Continued From page 18	{F 657}		

On 11/1/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #223 the facility staff failed to update the care plan to include side rails.

On the morning of 10/30/23 Resident #223 was observed resting in bed with mattress sliding off the side of the bed frame, the mattress was hanging over the edge about 3-4 inches. Upon closer inspection of the bed frame, it was discovered that there were no mattress retainers on the bed frame. The bed had no type of bed rails or other positioning device attached.

10/31/23 at 1:00 PM Resident #223 was observed in bed resting with eyes closed and the bottom of mattress was slightly hanging over the frame about 2-3 inches.

On 11/1/23 at 2:00 PM observation was made of Resident #223 in bed resting with eyes closed and 1/2 rails were present on bed.

On 11/1/23 at 2:37 PM an interview was conducted with the maintenance director who stated that he was called by the Administrator to put siderails on Resident #223's bed.

A review of Policy #2602 entitled "Care Planning," revealed excerpts that read as follows: "Procedure -"6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment."

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{F 657}	Continued From page 19 On 11/1/23 at approximately 4:30 p.m. an interview was conducted with the Corporate Nurse Consultant who was asked if the care plan should have been reviewed and revised when the bed rails were applied to the bed, she stated that it should have been. On 11/2/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	{F 657}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation review, the facility staff failed to provide services that meet professional standards of care for one Resident (#214), in a survey sample of 32 Residents. The findings included: For Resident #214 the facility staff 1. failed to provide care and maintenance of a PICC (peripherally inserted central catheter) line according to professional standards; and 2. failed to provide wound care in accordance with standards of practice as evidenced by failure to date dressings and replace dressings as per physician orders. 1. On 10/30/23 during clinical record review it was	{F 658}	F658 1. Resident #214□s PICC line was discontinued and removed on 10/30/23. Resident #214 is receiving care and services for wound care to include dating of dressings and replacement of dressings per physician orders. 2. Residents with PICC lines and wounds are at risk. Residents with PICC lines will be reviewed to ensure that care and services meeting professional standards are provided. Resident dressings will be reviewed to ensure that the dressing is dated and documented per physician order. 3. All Nurses will be educated by the DON/designee on provision of care and	12/18/23

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{F 658}	Continued From page 20 found that Resident # 214 had a PICC line ordered to administer Meropenem (an intravenous-IV antibiotic) for an infected pressure wound to the right foot. Excerpts from the progress notes are as follows: "10/2/2023 4:04 PM Order Note Text: N.O for IV ABT, PICC line placement has been ordered and [name redacted] RN @ [phone number redacted] infusion service he states he will come late tonight of early morning." "10/2/2023 4:08 PM Health Status Note Text: [Hospital Name Redacted/ MD name redacted] eval and new order meropenem 1 gram iv q 8 hrs. for 21 days for ulcer of right foot. rp [responsible party] notified." "10/2/2023 10:29 PM Health Status Note Text: Infusion service in to insert double lumen PICC line in right upper arm. Mobile Imagining in to confirm placement at 7:00pm. Tech stated that the preliminary results show the PICC is in the right place and ok to start ABT therapy. Awaiting the final results. Resident and RP made aware." "10/3/2023 11:33 AM Health Status Note Text: PICC support made aware of PICC line confirmation results and stated the PICC line is in the right place and able to be used. Resident and RP made aware." A review of the physician order revealed that although the PICC line was inserted on 10/2/23 the Resident did not receive the following orders until 10/23/23: "PICC line - Measure external portion of PICC	{F 658}	services to meet professional standards of PICC line care and on dating dressings and replacement of dressings per physician orders. 4. The UM/designee will review provision of services for care of PICC lines and dating of dressings and replacement of dressings per physician order weekly times 4 and monthly times 2. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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line catheter weekly with dressing changes every day shift every Mon Other 10/23/2023 at 7:00" "PICC line dressing change Q week and PRN every day shift every Mon 10/23/2023 at 7:00"

On 10/30/23 at 4:20 PM an observation was made of the PICC Line in Resident #214's upper right arm. There was a bio-occlusive [Tegaderm] to the upper right arm that was undated, peeled back, not intact thus, leaving the insertion site of the PICC line exposed to air. RN B (Registered Nurse-B)was at bedside and asked if the bio-occlusive was dated she stated that it was not. RN B was asked the importance of dating a dressing she stated that the dressing should be dated so the staff would know when the dressing was last changed. When asked if the PICC should be left open to air she stated that it should not. When asked why RN B stated that a PICC line goes into the chest and leaving it open to air could increase the risk of infection. When asked how often a PICC line dressing should be changed she stated it should be changed weekly. When asked what some other considerations are when caring for a Resident with a PICC line, she stated that the arm circumference should be measured. When asked why the circumference of the arm should be measured, she stated that it's the only way to know if the arm starts to swell. When asked how often it should be measured, she stated weekly and PRN. RN B stated that the external PICC line should also be measured weekly. When asked why this is important, she stated so that you will know if the catheter is tunneling in or backing out. When asked how often this should be done, she stated weekly and PRN (as needed).

On 10/31/23 a review of the document entitled

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"Infusion IV access line maintenance protocol" was conducted and excerpts are as follows: "PICC Line - Transparent dressing changes - On admission or 24 hours post insertion, then weekly & PRN. Measure upper arm circumference and exterior catheter length with each dressing change and PRN."

On 10/31/23 at 2:38 PM an interview was conducted with the Regional Nurse Consultant who was asked where the documentation would be for the circumference of the arm and the external PICC line measurements, she indicated they should be in a progress note or in the MAR / TAR (Medication Administration Record / Treatment Administration Record). She stated that she did not find them in the chart or MAR / TAR.

The following are excerpts from Lippincott regarding PICC LINE care: https://www.nursingcenter.com/static?pageid=822689

"Dressing changes: After PICC insertion, the catheter exit site is initially dressed with gauze and transparent dressing. Occasionally there is oozing of blood at the insertion site post-procedure. This initial gauze dressing should be changed, and the site assessed after 24 hours to prevent the risk of infection. According to the CDC guidelines, gauze dressing should be replaced every 2 days and transparent dressings every 7 days, unless the dressing becomes loose, damp, or soiled. "

"When to remove the PICC -The decision to remove a central catheter is based on discontinuation of therapy or signs of

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{F 658}	Continued From page 23 complications. " "The PICC should be inspected after removal to ensure that the length of the catheter is the same as the documented insertion length. If the catheter removed is shorter than the documented length the physician should be notified." On 10/31/23 during the end of day meeting the Administrator was made aware of the concern and no further information was provided. 2. For Resident #214, the facility staff failed to provide wound care in accordance with standards of practice as evidenced by failure to date dressings and replace dressings as per physician orders. On 10/31/23, Surveyors C and D observed Resident #214's wounds with LPN B (Licensed Practical Nurse-B) and RN B. Upon removal of the prevalon boots from the feet, it was noted that the dressings in place were severely discolored from drainage and soilage. There was no date on the dressing to indicate when it was last changed. Also, the wound on Resident #214's left ischium (the lower and back part of the hip bone), had no dressing to protect the wound from contamination from urine and feces; the Resident was incontinent. During the observations, interviews were conducted with LPN B and RN B. Both nurses confirmed that dressings were to be replaced when soiled or when accidentally removed and all dressings were to be dated. Review of Resident #214's physician orders	{F 658}		

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{F 658}	Continued From page 24 revealed an order that read, "Left Ischium - clean with NS/WC [normal saline/wound cleanser], apply Santyl and cover with foam dressing daily and PRN [as needed] ...". Review of the facility policy titled; "General Wounds Care/Dressing Changes" was conducted. This policy read, "... 4. Remove and reapply dressings as ordered and/or indicated. 5. Licensed nurses will follow recognized standards of practice regarding dressing change(s), including date and initials on dressing...". On 10/31/23, during an end of day meeting, the facility Administrator, Director of Nursing (DON), and Regional Director of Clinical Services were made aware of the above findings. The DON confirmed that she expected dressings to have the date and initials of the nurse applying the dressing. No further information was provided.	{F 658}		
{F 677} SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on Resident interview, facility staff interview, clinical record review and facility documentation review, the facility staff failed to provide assistance with activities of daily living (ADL) for three Residents (Resident #205, #207, and #214) to maintain good personal hygiene, in a survey sample of 3 Residents reviewed for ADL	{F 677}	F677 1. Residents #205, 207, and 214 are receiving showers according to their preferences. 2. All Residents have the potential to be affected. Residents will be reviewed for	12/18/23

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{F 677}	Continued From page 25 care. The findings included: For Residents #205, #207, and #214, all who required staff's assistance with ADL's, the facility staff failed to provide baths and/or showers to maintain personal hygiene. On 10/30/23 and 10/31/23, clinical record reviews were conducted of Resident #205, #207 and #214's chart, with special attention to ADL care. The following was noted: 1. Resident #205 received 3 showers from October 9, 2023-October 31, 2023. Resident #205 was noted to be totally dependent upon facility staff for bathing. The occurrences of a shower occurred on 10/12/23, 10/16/23, and 10/23/23. There was no documentation of refusals of showers noted. 2. Resident #207, received 3 showers from October 9-October 31, 2023. Resident #205 was noted to be dependent upon facility staff for the task of bathing. Resident #207's showers occurred on 10/16/23,10/21/23 and 10/23/23. Resident #205 went 7 consecutive days, 10/9-10/15/23, without receiving a shower to maintain personal hygiene. There was not any documentation that the Resident had refused showers. 3. Resident #214, who was total care and was incontinent and had wounds, had not had a shower since 10/20/23. The Resident's bathing records, and ADL reports indicated she had received only 2 showers from Oct 9-Oct 31, 2023. the showers took place on 10/9/23 and 10/20/23.	{F 677}	provision of showers according to their preference. 3. The SDC/designee will educate all CNAs and Nurses on provision of showers as per the Resident□s preference and documentation of the shower, bath, or refusals of either. 4. The UM/designee will review provision of showers weekly times 4 and monthly times 2 to ensure that showers are provided. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 677}	Continued From page 26	{F 677}		

There was no documentation to indicate the Resident had refused showers.

On the morning of 10/31/23, Surveyor D attempted to interview the Residents. Resident #205 would only nod her head and was not consistent with her responses. Resident #214 was non-verbal and not able to be interviewed. Resident #207 did participate in the interview. When asked about showers, Resident #214 stated she and her roommate (Resident #205)'s shower days were Monday's. When asked if she was happy with the frequency, Resident #214 stated she would like to receive them twice weekly.

On 10/31/23 at approximately 12:05 PM, an interview was conducted with RN B. When asked about showers, RN B said, "They are given twice a week." RN B confirmed that they do not have a bath team and the assigned CNA (certified nursing assistant) is responsible for giving the bath/shower. When asked how refusals are handled, RN B said, "They let the nurse know and we chart it."

RN B assisted with showing and providing Surveyor D a copy of the shower schedule. Review of this document revealed Residents #205 and #207 were scheduled to receive showers on Monday and Thursdays on the 7AM - 3 PM shift. Resident #214 was scheduled to receive showers on Monday and Thursdays during the 3-11 PM shift.

On 10/31/23 at 12:34 PM, an interview was conducted with the facility's Director of Nursing (DON). The DON said, "Showers are given as per the schedule, twice a week." When asked

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{F 677}	Continued From page 27 who gives the showers, the DON said, "The assigned CNA." The DON went on to explain that if the Resident refuses, they go back and offer again later, if they continue to refuse the CNA will let the nurse know, who will go and encourage it. If after 3 times they still decline, [the staff] give a bed bath and change their bed linen, the nurse notifies the responsible party and documents it. The facility administration was asked to provide a facility policy with regards to bathing. The policy titled, "Shift Responsibilities for CNA" with an effective date of 11/1/19, was provided. This policy read, "1. CNAs will report to a designated unit at the beginning of a shift to obtain the shift responsibilities/patient assignment as determined by a licensed nurse. 2. Obtain patient assignment at the beginning of each shift from/with a licensed nurse. Examples of general report information includes but is not limited to: the patient's name, room and bed, scheduled appointments, bathing needs, special health care needs, etc. 3. Provide pertinent patient information to the on-coming shift, such as tasks not completed, etc. 4. Perform shift responsibilities/assignments that promote quality of care; make rounds, identify, and address any immediate patient needs, promptly respond to call lights and notify the licensed nurse of any pertinent findings (reddened skin, etc.)." On 10/31/23, during an end of day meeting, the facility Administrator and DON were made aware of the above findings. No further information was received.	{F 677}		
{F 684} SS=D	Quality of Care CFR(s): 483.25	{F 684}		12/18/23

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{F 684}	Continued From page 28 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for one Resident (#214) in a survey sample of 32 Residents. The findings included: For Resident #214, the facility staff failed to provide weekly dressing changes to the PICC (Peripherally Inserted Central Catheter) as ordered by the physician and failed to document the external PICC line and arm circumference measurements and when removing the PICC line failed to document the measurement of the PICC line and inspection of the catheter tip when RN B pulled (removed) the PICC LINE per facility policy and standards of nursing practice. On 10/30/23 during clinical record review it was found that Resident # 214 had a PICC line ordered to administer Meropenem (an intravenous-IV antibiotic) for an infected pressure wound to the right foot.	{F 684}	F684 1. Resident #214□s PICC line was discontinued and removed on 10/30/23. 2. Residents with PICC lines will be reviewed to ensure care and treatment is provided in accordance with professional standards. 3. All Nurses will be educated by the DON/designee on provision of care and treatment of PICC lines to include documentation of the external PICC line and arm circumference when removing the PICC line, measurement of the PICC line and inspection of the catheter tip upon removal of the line. 4. The UM/designee will review documentation of provision of care and treatment for PICC lines weekly times 4 and monthly basis times 2 to ensure that appropriate care and management of PICC lines is provided. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 684}	Continued From page 29	{F 684}		

Excerpts from the progress notes are as follows:

"10/2/2023 4:04 PM Order Note Text: N.O for IV ABT (antibiotic), PICC line placement has been ordered and [name redacted] RN @ [phone number redacted] infusion service he states he will come late tonight of early morning."

"10/2/2023 4:08 PM Health Status Note Text: [Hospital Name Redacted/ MD name redacted] eval and new order meropenem 1 gram iv q 8 hrs. for 21 days for ulcer of right foot. rp [responsible party] notified."

"10/2/2023 10:29 PM Health Status Note Text: Infusion service in to insert double lumen PICC line in right upper arm. Mobile Imagining in to confirm placement at 7:00pm. Tech stated that the preliminary results show the PICC is in the right place and ok to start ABT therapy. Awaiting the final results. Resident and RP made aware."

"10/3/2023 11:33 AM Health Status Note Text: PICC support made aware of PICC line confirmation results and stated the PICC line is in the right place and able to be used. Resident and RP made aware."

A review of the physician order revealed that although the PICC line was inserted on 10/2/23 the Resident did not receive the following orders until 10/23/23:

"PICC line - Measure external portion of PICC line catheter weekly with dressing changes every day shift every Mon Other 10/23/2023 at 7:00"

"PICC line dressing change Q (every) week and PRN (as needed) every day shift every Mon

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{F 684}	Continued From page 30 10/23/2023 at 7:00" On 10/30/23 at 4:20 PM an observation was made of the PICC Line in Resident #214's upper right arm. There was a bio-occlusive [Tegaderm] to the upper right arm that was undated, peeled back, not intact thus, leaving the insertion site of the PICC line exposed to air. RN B (Registered Nurse-B)was at bedside and asked if the bio-occlusive was dated she stated that it was not. RN B was asked the importance of dating a dressing she stated that the dressing should be dated so the staff would know when the dressing was last changed. When asked if the PICC should be left open to air she stated that it should not. When asked why RN B stated that a PICC line goes into the chest and leaving it open to air could increase the risk of infection. When asked how often a PICC line dressing should be changed she stated it should be changed weekly. When asked what some other considerations are when caring for a Resident with a PICC line, she stated that the arm circumference should be measured. When asked why the circumference of the arm should be measured, she stated that it's the only way to know if the arm starts to swell. When asked how often it should be measured, she stated weekly and PRN. RN B stated that the external PICC line should also be measured weekly. When asked why this is important, she stated so that you will know if the catheter is tunneling in or backing out. When asked how often this should be done, she stated weekly and PRN. On 10/31/23 a review of the document entitled "Infusion IV access line maintenance protocol" was conducted and excerpts are as follows:	{F 684}		

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"PICC Line - Transparent dressing changes - On admission or 24 hours post insertion, then weekly & PRN. Measure upper arm circumference and exterior catheter length with each dressing change and PRN."

On 10/31/23 at 2:38 PM an interview was conducted with the Regional Nurse Consultant who was asked where the documentation would be for the circumference of the arm and the external PICC line measurements, she indicated they should be in a progress note or in the MAR / TAR (Medication Administration Record / Treatment Administration Record). She stated that she did not find them in the chart or MAR / TAR.

The following are excerpts from Lippincott in regard to PICC LINE care: https://www.nursingcenter.com/static?pageid=822689

"Dressing changes: After PICC insertion, the catheter exit site is initially dressed with gauze and transparent dressing. Occasionally there is oozing of blood at the insertion site post-procedure. This initial gauze dressing should be changed, and the site assessed after 24 hours to prevent the risk of infection. According to the CDC guidelines, gauze dressing should be replaced every 2 days and transparent dressings every 7 days, unless the dressing becomes loose, damp, or soiled. "

"When to remove the PICC -The decision to remove a central catheter is based on discontinuation of therapy or signs of complications. "

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{F 684}	Continued From page 32	{F 684}		

"The PICC should be inspected after removal to ensure that the length of the catheter is the same as the documented insertion length. If the catheter removed is shorter than the documented length the physician should be notified."

A review of the progress notes revealed the following notes on discontinuing PICC line:

"10/30/2023 4:33 PM Health Status Note Text: NP (nurse practitioner) aware that resident has completed ABT (antibiotic) therapy. New order to D/C (discontinue) PICC line. Resident and RP made aware."

"10/30/2023 4:53 PM Orders - Administration Note Text: PICC line dressing change Q week and PRN every day shift every Mon PICC line D/C'd."

"10/30/2023 4:54 PM Orders - Administration Note Text: PICC line - Measure external portion of PICC line catheter weekly with dressing changes every day shift every Mon PICC Line D/C'd."

"10/31/23 3:40 AM - Health Status Note Text: Resident alert and non-verbal. Vital signs stable with no gestures of pain or discomfort. Receive schedule pain medication and it is effective. On charting for removal of PICC line. No adverse reactions and no bleeding noted at this time. Resident resting in bed with eyes closed. Call light within reach and all safety precautions in place."

On 10/31/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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{F 686}	Continued From page 33	{F 686}		
{F 686} SS=J	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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care consistent with standards of practice to promote the healing of and prevent infection of pressure ulcers for one Resident (Resident #214) in a survey sample of four Residents reviewed for pressure ulcers, resulting in harm for Resident #214. Immediate Jeopardy (IJ) was identified on 10/31/23 at 3:10 PM, at which time the facility Administrator and Director of Nursing were made aware. Following verification of the removal of immediacy the facility abated the IJ on 11/3/23 at 3:15 PM. The scope and severity was lowered to a level 3, isolated. The findings included: For Resident #214, the facility staff failed to	{F 686}	F686 1. Resident #214 is receiving timely and accurate skin assessments, treatments as ordered, and remains without infection. 2. Residents with wounds will be reviewed to ensure that they are receiving accurate skin assessments, treatments and medications as ordered, and signs/symptoms of infection are communicated to the physician. 3. All Nurses will be educated on documentation of skin observations, documentation of treatments and medications as ordered, and communication of signs/symptoms of infection to the physician. 4. The UM/designee will review documentation of skin observations, treatment and medication administration,	12/18/23

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{F 686}	Continued From page 34 conduct timely and accurate skin assessments, which included failure to identify wounds, and signs of wound infection; and failed to provide treatment to wounds in accordance with physician orders, resulting in wound deterioration, which constituted harm. On 10/30/23, Resident #214's clinical record was reviewed and revealed the following: a. The most recent note by the wound care specialist dated 10/11/2023, indicated the resident had a stage III wound (1) to her left medial heel, the wound was noted as being stable with 100% granulation tissue. The note also indicated Resident #214 had an unstageable pressure wound (2) to her left lateral ankle. This wound was noted as "stable" with "Exudate amount: Moderate, Exudate Description: Serosanguineous." b. The treatment orders in the wound care specialist's note to the left medial heel and the left lateral ankle read as follows: "cleanse with wound cleanser, silver alginate, bordered foam, rolled gauze, every other day." c. Review of the active physician orders and treatment administration record revealed the wound care specialist's orders were not carried out and the orders/treatment being applied were based on orders dated 9/15/22, which read, "clean with NS/WC [normal saline/wound cleanser], apply silvercel cover with dry dressing daily." d. Resident #214 had a "skin observation tool," dated 10/27/2023, performed by a facility RN. The RN failed to identify either of the wounds to the left lateral heel or left lateral foot. e. Resident #214 was ordered to receive 21 days of IV [intravenous] antibiotic starting 10/3/23, for a right foot post operative wound infection, which	{F 686}	and physician notification of signs/symptoms of infection weekly times 4 and monthly times 2. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 686}	Continued From page 35	{F 686}		

was ordered by the infectious disease doctor. The note from the Infectious Disease doctor noted Resident #214 had a history of multiple drug resistant A. Baumannii [Acinetobacter baumannii- an organism that can cause infections in the blood, urinary tract, and lunch, or in wounds in other parts of the body] infection. The Resident missed 5 consecutive doses.

On 10/30/2023 at 2:55 p.m., Surveyor C and D made observations of the wounds with LPN B (licensed practical nurse-B) and RN B(registered nurse-B). Upon observation of the right and left foot wounds, it was noted the dressing in place was brownish yellow in color from drainage. There was no date to indicate when the dressings were last changed. RN B and LPN B were asked to describe what was being seen. Both acknowledged the bandage was saturated and brown in color, and it did not appear the dressings had been changed the day prior as ordered.
Upon removal of the dressing, there was a significant foul odor. There was brown, yellowish, and green tinted exudate noted in a wound that was on the plantar of the foot across the metatarsal joint region, and the exudate was copious. LPN B and RN B confirmed the odor and exudate. The wound bed was not able to be visualized.

Following the observations of Resident #214's wound on 10/30/2023, and acknowledgement of signs of infection confirmed by 2 facility staff, the following was noted:

On 10/31/23, the clinical chart of Resident #214 was reviewed again and revealed no evidence that the facility staff had notified the physician of

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the observed changes in the wounds and signs of infection as evidenced by malodor and copious exudate that had been observed the day prior.

The facility policy titled; "General Wound Care/Dressing Changes" was reviewed. This policy read, "A licensed nurse will provide wound care/dressing change(s) as ordered by physician. Procedure: 1. Notify the physician and obtain orders for treatment(s) and dressing changes... 3. Provide treatments as ordered. 4. Remove and reapply dressings as ordered and/or indicated... 9. Document in progress notes any unusual findings and follow-up interventions including notification of physician/responsible party".

The facility's Regional Director of Clinical Services identified Lippincott as their nursing standard of practice. According to the "Lippincott Manual of Nursing Practice, Eighth Edition", chapter 32, on page 1090 stated the following: "Osteomyelitis is a severe pyogenic infection of the bone and surrounding tissues that requires immediate treatment ... Management: ... 2. Chronic: develops with inadequate or ineffective course of antibiotics or delayed treatment ... Complications: 1. Nonhealing wound, 2. Sepsis, 3. Immobility, 4. Amputation ...".

The Lippincott manual of Nursing Practice also stated, in "Chapter 2: Standards of Care, Ethical and Legal Issues" on page 18, "Common Legal Claims for Departure from Standards of Care: Failure to monitor or observe a patient's clinical status adequately, Failure to monitor or observe a change in a patient's clinical status, failure to communicate or document a significant change in a patient's condition to the appropriate professional ... Failure to implement a

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physician/NP [nurse practitioner]/PA [physician assistant] order properly or in a timely fashion, Failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately ... failure to prevent infection ...".

Immediately Jeopardy was identified on 10/31/23 at 3:10 PM, at which time the facility Administrator and Director of Nursing were made aware.

On 11/1/23 at 1:15 PM, the facility submitted an accepted IJ removal plan, which read as follows: "A skin assessment will be conducted on all current residents to include accurate documentation of wounds and identification of signs/symptoms of wound infection. The physician will be notified of any new wounds, changes in the wound status, and/or signs/symptoms of infection. Resident #214's physician was notified of the changes in the wounds and signs/symptoms of infection on 10/31/23.

Education will be provided by Nursing Administration to all licensed nurses concerning care and services for provision of appropriate care of residents with wounds to include timely assessment of wounds, timely identification of wounds, identification, and response to signs/symptoms of infection, and physician notification of changes to wounds. Education will be provided to CNAs (certified nursing assistants) on reporting any changes noted in skin through verbal report to the nurse. The nurses will be educated on identification of new wounds and reporting the new wounds to the wound practitioner and Resident physician. The nurses will be educated on signs/symptoms of wound

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infection to include odor, increased drainage, change in wound color of wound bed, warmth to the surrounding area. The nurses will be educated on notifying the physician of changes to wounds. Nurses will be educated on initialing and dating of dressings prior to placing a dressing on the resident. The wound practitioner will assess residents with wounds on a weekly basis.

All nurses and CNAs on duty will be educated on the above and all nurses and CNAs coming on duty will be educated on the above prior to being permitted to work.
Completion date 10:00 am on 11/2/23."

On 11/2/23 at 10:40 AM, the facility administration submitted to the survey team credible evidence of the IJ immediacy removal plan. Included in the documents was evidence of skin assessments completed on all Residents and the staff education. On 11/2/23, the survey team selected a sample of Residents to observe their skin to identify any skin impairments and verify that any impairments and/or signs of infection had been appropriately identified and communicated to the doctor. During this verification the air mattress for Resident #214 was inadvertently deflated when the head of the bed was elevated and the Resident had to be changed to another mattress, so the observation had to be suspended. When Resident #225 was going to be observed, the Director of Nursing noted that the low-pressure light was on, and her air mattress was not functioning properly, and this observation had to be suspended as well.

On 11/3/23, the survey team returned to the facility to verify the abatement of IJ. Upon review, it was noted that for several Residents, which

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included Resident #214, the skin assessment was inaccurate and didn't identify all skin impairments. Also, there were 4 staff that had worked the night shift from 11/2-11/3, that had no evidence of having received training and 2 current staff working that had no evidence of having received training as noted in the facility's IJ removal plan.

On 11/3/23 at 12:28 PM, the facility Administrator, Director of Nursing (DON) and Regional Director of Clinical Services were made aware that the survey team had not been able to verify the abatement of IJ for the above noted reasons.

On 11/3/23 at 12:34 PM, the DON provided the survey team with a progress note written 11/3/23 at 11:49 AM, from Resident #214's attending physician. The note read, "I was notified by the charge nurse that patient missed the doses of iv antibiotics. Since patient has chronic persistent wounds but clinically had no fever, I ordered blood work and wound culture and advised the wound care NP to assess the wound again before giving her another round of antibiotics and exposing her unnecessarily to antibiotics and increasing the risk of resistant and c. diff [sic]". There was no indication that the missed doses of IV antibiotics were discussed with the infectious disease doctor who ordered the IV antibiotics and there was no evidence in the clinical chart of wound cultures being obtained/conducted as per this note.

Following the inability to abate IJ on 11/2/23-11/3/23, the provider submitted a revised IJ removal plan with the only change being the date and time they would complete the plan: the revision indicated it would be complete on 11/3/23

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{F 686}	Continued From page 40 at 2 PM. On 11/3/23, in the afternoon the survey team attempted again to verify the facility staff had implemented their approved IJ immediacy removal plan. Staff interviews were conducted with facility staff from the nursing department to ensure they had received training. A revised skin assessment for Resident #214 was submitted to the survey team. The survey team obtained a Resident census listing and cross checked to ensure that all Residents had a skin assessment and a sample of 10% of the Residents had skin observations conducted by the survey team. The survey team confirmed Immediate Jeopardy was abated on 11/3/23 at 3:15 PM. References: https://www.cms.gov/files/document/pocket-guide pressure-ulcers-and-injuries-stages-and-definitions.pdf (1) Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue. (2) Unstageable-Pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar.	{F 686}		
{F 689} SS=J	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}		12/18/23

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{F 689}	Continued From page 41 §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, interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from accident hazards for one Resident (#223) in a survey sample of 32 Residents. Immediate Jeopardy (IJ) was identified on 11/2/23 at 12:10 PM, at which time the facility Administrator and Director of Nursing were made aware. Following verification of the removal of immediacy the facility abated IJ on 11/3/23 at 4:15 PM. The scope and severity were lowered to a level 2, pattern. The findings included: For Resident # 223 the facility staff failed ensure the mattress was secured to the bed so that it did not slide off the bed frame. On the morning of 10/30/23 Resident #223 was observed resting in bed with the mattress sliding off the side of the bed frame, the mattress was hanging over the edge about 3-4 inches. Upon closer inspection of the bed frame, it was discovered that there were no mattress retainers on the bed frame. The bed had no type of bed rails or other positioning device attached. On 10/31/23 at 1:00 PM Resident #223 was observed in bed resting with eyes closed; the side of the mattress was slightly hanging over the frame about 2-3 inches.	{F 689}	F689 1. Resident #223□s mattress has been secured to the bed. 2. All Residents have the potential to be affected. All beds will be visualized to ensure that the mattress is secured to the bed. 3. All Nursing, Maintenance, and Housekeeping staff will be educated by the SDC/designee on ensuring that the bed mattress is safely secured to the bed frame. 4. The UM/designee will review mattress placement weekly times 4 and monthly times 2 to ensure that the mattress is safely secured to the bed frame. Results of the reviews will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 689}	Continued From page 42 On 10/31/23 at approximately 1:00 PM on an interview was conducted with RN C (registered nurse-C) who was asked about the overlap, and she stated that this does pose a problem if the Resident were to sit on the edge of the bed they could possibly slide to the floor since the mattress was not on the bed frame properly. On 11/1/23 a review of the clinical record revealed that Resident #223 had no orders and was not care planned for side rails. On 11/1/23 at 2:00 PM observation was made of Resident #223 in bed resting with eyes closed and 1/2 side rails were present on bed. On 11/1/23 at 2:37 PM an interview was conducted with the maintenance director who stated that he was called by the Administrator to put siderails on Resident #223's bed. When asked why he stated, "They don't tell me why, all I know is they have to do an assessment and then whatever the reason the Resident needs a siderail they contact me, and I put the rail on and do an entrapment assessment." When asked if this bed had mattress guards to keep the mattress from sliding off the bed he stated, "No, the bed is too old, it's a discontinued model." On 11/1/23 at 3:00 PM an interview was conducted with the Administrator who stated that he spoke with someone from the company that manufactured the bed and was told that the bed was too old and there were no mattress stops and that they could use a bed rail to secure the mattress to the bed. When asked if he was saying that the bed rail was being used to secure the mattress to the bed, he stated that it was.	{F 689}		

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On 11/1/23 at 3:15 PM a policy for "Bed Rails" was requested and the surveyors were told there is no policy at the facility specific to bed rail use. A device policy was submitted to the survey team. A review of the facility policy read:

"Policy Name: Medical Equipment"
"Policy: Nursing will follow manufacturer's recommended guidelines on all medical equipment and clinical devices."

The manufacturer emailed the surveyors a copy of a document called "Entrapment Risk Mitigation excerpts are as follows:

"The specifics for these best practice guidelines were developed from a review of the incident responses received and pertain to dimensional and clinical criteria. The risk of entrapment increases with large gaps or openings in the bed system that could entrap a patient's neck, head, or chest. Gaps can be caused by mattresses that are not the correct recommended size, loose side rails, or design elements such as wide spaces between the openings in the rails."

"Since the development of the Bed entrapment guidelines CMS has created F-Tags 700 and 909 pertaining to the use of bedrails and regular inspection of the bed system. These updates have utilized the guidance set forth by the HBSW but added that when a rail is in use on a bed, this must be specified to that patient and documented accordingly. This means that for each admission documentation is required for bed rail use and bed systems should be checked frequently for entrapment compliance."

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{F 689}	Continued From page 44 On 11/2/23 at 9:04 AM a phone call was placed to the manufacturer of the bed and when asked if this bed (Model 330 B) had mattress stops or guides to keep the mattress from sliding off the frame, the employee stated this is an old bedframe and it did not have built in mattress guides or stops at the time the bed was manufactured. The product support specialist for the manufacturer stated that "Mattress stops are available for sale as an accessory for the bed. When asked if the manufacturer would recommend using side rails to stop the mattress from sliding, he stated "It is the position of our company that side rails are used only for the needs of the Residents. The Resident must be evaluated, and it must be documented that they need the rails for positioning and as an assistive device. There are regulations that vary from state to state about using siderails as positioning devices, but they are NOT recommended to be used to secure a mattress in place to a bed. For securing the mattress our company has mattress stops available for purchase." Immediate Jeopardy (IJ) was identified on 11/2/23 at 12:10 PM, at which time the facility Administrator and Director of Nursing were made aware. On 11/2/23 at 4:15 PM, the facility submitted an accepted IJ removal plan which read as follows: "11/2/23 - Resident # 223's bed has been replaced with a bed which has a secured mattress. An audit of all facility beds will be conducted to identify any unsecured mattresses. The unsecured mattresses will be corrected to prevent accident hazard. An audit of all bed side rails will be completed to determine the need for	{F 689}		

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{F 689}	Continued From page 45 the bed side rail and if the resident is at risk of entrapment. Bed side rails determined to be unnecessary will be removed from the bed. All facility staff will be educated on identification of safety hazards related to unsecured mattresses and side rails. All nurses will be educated by Nursing Administration on completion of a bed side rail assessment prior to initiation of bed side rails to ensure the bed side rail is appropriate that risks and benefits have been explained to the resident and/ or responsible party and plan to reduce the use of bed side rail is documented. All staff on duty will be educated on the above and those coming on duty will be educated on the above prior to being permitted to work. Completion date: 11/3/23 12 noon." The survey team verified that education was conducted and the measures stated in the plan were implemented by the facility staff. Immediate Jeopardy was abated on 11/3/23 at 4:15 PM. On 11/3/23 during the end of day meeting, the Administrator was made aware of the concerns; no further information was provided.	{F 689}		
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.	F 700		12/18/23

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F 700	Continued From page 46 §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, interview, clinical record review, and facility documentation review, the facility staff failed to review for risk and benefits and assess for entrapment, prior to installing bed rails for two Residents (#223, #214), in a survey sample of 32 Residents. The findings included: 1. For Resident #223 the facility installed bedrails without proper assessment in response to surveyor inquiry of an unsecured mattress. On the morning of 10/30/23 Resident #223 was observed resting in bed with the mattress sliding off the side of the bed frame, the mattress was hanging over the edge about 3-4 inches. Upon closer inspection of the bed frame, it was discovered that there were no mattress retainers on the bed frame. The bed had no type of bed rails or other positioning device attached. On 10/31/23 at 1:00 PM Resident #223 was observed in bed resting with eyes closed bottom of mattress slightly hanging over the frame about	F 700	F700 1. Resident #223 has been reassessed and does not utilize bed rails. Resident #214 has been reassessed and does not utilize bed rails. 2. Residents will be reviewed to identify those requiring bed rails and documentation of the bed rail assessment. 3. All Nurses will be educated by the DON/designee on assessment of bed rail use to include alternatives, risk of entrapment, consent, risks and benefits of bed rail use, informed consent, bed dimensions, and manufacturer□s recommendations. 4. The DON/designee will monitor use of bed rails weekly times 4 and monthly times 2 to ensure that bed rails are assessed prior to use. Results of the reviews will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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2-3 inches.

On 10/31/23 at approximately 1:00 PM, an interview was conducted with RN C (registered nurse-C) who was asked about the overlap, and she stated that this does pose a problem if the Resident were to sit on the edge of the bed they could possibly slide to the floor since the mattress was not on the bed frame properly.

On 11/1/23 at 2:00 PM observation was made of Resident #223 in bed resting with eyes closed and 1/2 rails were present on bed.

On 11/1/23 at 2:15 PM a review of the clinical record revealed that Resident #223 had no side rail assessment, no orders and was not care planned for side rails.

On 11/1/23 at 2:37 PM an interview was conducted with the maintenance director who stated that he was called by the Administrator to put siderails on Resident #223's bed. When asked why he stated, "They don't tell me why, all I know is they have to do an assessment and then whatever the reason the Resident needs a siderail they contact me, and I put the rail on and do an entrapment assessment." When asked if this bed had mattress guards to keep the mattress from sliding off the bed he stated, "No, the bed is too old, it's a discontinued model."

On 11/1/23 at 3:00 PM an interview was conducted with the Administrator who stated that he spoke with someone from the company that manufactured the bed and was told that the bed was too old and there were no mattress stops and that they could use a bed rail to secure the mattress to the bed. When asked if he was

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F 700	Continued From page 48	F 700		

saying that the bed rail was being used to secure the mattress to the bed, he stated that it was. When asked if the Resident had an assessment for side rails none could be found in the electronic health record.

The manufacturer emailed the surveyors a copy of a document called "Entrapment Risk Mitigation excerpts are as follows:

"The specifics for these best practice guidelines were developed from a review of the incident responses received and pertain to dimensional and clinical criteria. The risk of entrapment increases with large gaps or openings in the bed system that could entrap a patient's neck, head, or chest. Gaps can be caused by mattresses that are not the correct recommended size, loose side rails, or design elements such as wide spaces between the openings in the rails."

"Since the development of the Bed entrapment guidelines CMS has created F-Tags 700 and 909 pertaining to the use of bedrails and regular inspection of the bed system. These updates have utilized the guidance set forth by the HBSW but added that when a rail is in use on a bed, this must be specified to that patient and documented accordingly. This means that for each admission documentation is required for bed rail use and bed systems should be checked frequently for entrapment compliance."

On 11/2/23 at 3:15 PM a policy for "Bed Rails" was requested and the surveyors were told there is no policy at the facility specific to bed rail use. A device policy was submitted to the survey team. A review of the facility policy read:

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F 700	Continued From page 49	F 700		

"Policy Name: Medical Equipment"
"Policy: Nursing will follow manufacturer's recommended guidelines on all medical equipment and clinical devices."

On 11/2/23 during the end of day meeting the Administrator was made aware of the concern, and no further information was provided.

2. For Resident #214, the facility staff failed to utilize alternatives and failed to assess for the risk of entrapment, prior to installing bed side rails.

On 10/31/23, Surveyors C and D visited Resident #214 in the room, facility staff (RN B and LPN B) were present. It was noted that Resident #214 was non-verbal, severely contracted, and unable to assist with her care, to include turning and repositioning. Facility staff were observed to provide total care of the Resident to turn and move her in bed, the Resident was able to offer no assistance. It was also noted that Resident #214's bed had bilateral 1/2 side rails.

Review of Resident #214's clinical record revealed the following:

a. Resident #214's care plan indicated, the Resident was "at risk for falls/injuries due to sensory deficit r/t [related to] MS [multiple sclerosis], Bulbar Palsy, cognitive impairment, incontinence, OP [osteoporosis], polyneuropathy, quadriplegia". Interventions included but were not limited to: "bilateral 1/4 rails to assist with turning and repositioning", which was dated 1/25/23 and "transfer using hoyer lift and 2 person assist", which was dated 10/26/22.

b. Resident #214's last assessment for the needs

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F 700	Continued From page 50 of side rails was conducted 8/24/23. This assessment in section "A. Type of device", was blank and indicated no devices were present. Section C. which read, "Purpose of the device(s)" was blank as well. There was no indication that other alternatives, risk of entrapment, review of the risks and benefits or informed consent were obtained prior to the installation of bed side rails. The facility administration reported to the survey team that they had no facility policy with regards to the use of bed side rails. On 11/3/23, the "Resident Handbook" and "Admission Agreement" were reviewed and revealed no information with regards to the use of bed rails. No further information was provided.	F 700		
{F 806} SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to	{F 806}	F806	12/18/23

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{F 806}	Continued From page 51 provide food and drinks in accordance with residents preferences for two residents, Residents #210 and #211, in a sample of 4 residents reviewed for food preferences. The findings included: On 10/30/23 at approximately 1:00 PM, observations of lunch tray distributions were conducted on the second floor nursing unit and revealed the following: 1. For Resident #210, the facility staff failed to honor the resident's documented food preferences. Resident #210's tray ticket indicated her food and beverage dislikes included but was not limited to "Beverages (Tea)", "Meats (Meatballs)", and "Vegetables (Tomato)". Resident #210's lunch tray included spaghetti with tomato sauce and meatballs and a cup of tea. 2. For Resident #211, the facility staff failed to honor the resident's documented food pretences. Resident #211's tray ticket indicated her food and beverage dislikes included but was not limited to "Other (Spaghetti)" and "Pasta". Resident #211's lunch tray included spaghetti with tomato sauce and meatballs. During the lunch tray distribution, an interview was conducted with RN B (registered nurse-B) who was assisting with the tray distribution. She confirmed the lunch trays for Residents #210 and #211 were not prepared correctly by dietary staff according to the Resident's dislikes that were documented on the lunch tray ticket located on	{F 806}	1. Resident #210 is receiving food per preferences. Resident #211 does not currently reside at the facility. 2. All Residents will be reviewed to ensure that food and drinks are served in accordance with their preferences. 3. Dietary staff will be educated on provision of food and drinks in accordance with Resident preferences as listed on the meal ticket. A designated staff member will check meals trays for preferences prior to the tray leaving the kitchen. 4. The Food Service Manager/designee will monitor provision of food and drinks per Resident preference weekly time 4 and monthly times 2. Results of the monitoring and interviews will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 806}	Continued From page 52 their lunch trays. On 10/30/23 at approximately 1:20 PM, the facility Administrator was shown Resident #210 and #211's lunch trays and tray tickets. He stated, "I expect the kitchen staff to prepare meal trays according to a resident's dietary order and food preferences, these trays do not meet my expectations." A facility policy was requested and received from the Facility Administrator. Review of the facility policy titled, "Food Preferences," subheading "Policy" read, "It is the policy of this facility to provide food preferences to residents while also allowing residents to make point of service choices that reflect individualized, day-to-day meal preferences with a reasonable effort". On 10/30/23, during an end of day meeting, the Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	{F 806}		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information 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	F 842		12/18/23

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professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(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.

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F 842	Continued From page 54 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for one Resident (Resident #214) in a survey sample of 32 Residents. The findings included: For Resident #214, the facility staff failed to maintain a complete and accurate clinical record to include all documentation from outside providers being entered into the clinical record in a timely manner. On 10/30/23 and 10/31/23, a clinical record review was conducted of Resident #214's electronic health record. It was noted that the most recent documentation with regards to a wound evaluation by the facility's consulted provider, was dated 10/11/23. The wound evaluation identified that Resident #214 had the following 8 wounds: a stage III pressure ulcer to the left first metatarsal, a stage III pressure ulcer to the left medial heel, an unstageable pressure	F 842	F842 1. Resident #214□s documentation in the medical record is currently accurate and complete. 2. Documentation from outside wound care providers will be reviewed for the past 30 days to ensure that the documentation is included in the Resident□s medical record. 3. The wound care provider will be educated on ensuring that documentation is successfully entered into the Resident□s medical record. 4. The DON/designee will monitor the wound care provider documentation weekly times 4 and monthly times 2 to ensure that the documentation is entered in a timely manner. Results of the reviews will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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wound to the left lateral ankle, an unstageable pressure ulcer to the left ischium, unstageable wounds to the right toes, a stage IV pressure wound to the right first metatarsal, an unstageable pressure wound to the right lateral ankle, and a skin tear/laceration to the right lateral foot.

There was a "Skin Observation Tool" dated 10/27/23, completed by a facility RN (Registered Nurse). This assessment only noted 4 areas of skin impairments. They were noted as, a stage III to the right outer ankle, an unstageable wound to the right toe(s), a stage III to the left great toe, and a stage IV to the right great toe. This assessment was inaccurate as it failed to note skin impairments/wounds to the left ischium, left lateral ankle, or left medial heel. On 10/31/23, Surveyors C and D conducted observations of Resident #214's wounds with LPN B (licensed practical nurse-B) and RN B. The Resident was noted to still have wounds on the left lateral ankle, left medial heel and left ischium. Therefore, the wounds would have been present when the RN conducted the skin assessment on 10/27/23.

On 10/31/23, it was confirmed with the facility's Director of Nursing (DON) that all records were in electronic format and there were no paper charts or hybrid charting system being used. The DON further confirmed that information from outside providers is scanned into the electronic health record by the medical records employee.

On 10/31/23, in the afternoon, an interview was conducted with the medical records employee. The medical records employee stated that all records had been scanned into the clinical records and she had no documents that were

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waiting to be scanned and uploaded, therefore all records available would be in the electronic chart.

On 10/31/23, during an interview with RN B who stated that Resident #214 was seen by the wound care specialist "last week." There was no documentation within the clinical record with regards to that.

On 11/1/23, at 11:30 AM the Regional Director of Clinical Services (RDCS) reported to the survey team, "I wanted to make sure you saw the progress note from the wound care practitioner dated 10/25/23." The survey team stated they would look at it. The RDCS also provided the survey team with "Wound Assessment Reports" totaling 8 pages that were dated 10/25/23, and she said, "They were not in [name of electronic health record system redacted]," indicating they were not included in the clinical record of Resident #214.

On 11/1/23, Surveyor D reviewed Resident #214's progress notes again and noted that there was a progress note dated 10/25/23 at 9:13 AM, titled "Skin and Wound Note." This note had not previously been present in the record. Upon further review, it was noted that the progress note was not entered into the clinical record until 10/31/23 at 21:53 and did not indicate it was a late entry.

The survey team met with the RDCS again to review the progress note and the RDCS confirmed it had not been entered into the record until late evening on 10/31/23, and therefore was not available for review previously. The RDCS stated that the wound care practitioner was new, and she didn't know what had happened and why

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F 842	Continued From page 57 it was not entered earlier. A review was conducted of the facility provided policy titled, "Documentation Summary" with an effective date of 11/1/19. Excerpts from this policy read, "... 3. Entries will be made as soon as possible after an event or observation is made... 4. Entries will not be pre-dated or backdated... 15. Late entries may be used when a pertinent entry was missed or note written in a timely manner. Identify the new entry as a "late entry" within the body of the narrative documentation. Enter the current date and time- do not try to give the appearance that the entry was made on a previous date or an earlier time. Identify or refer to the date and incident for which the entry is written. If the late entry is used to document an omission, validate the source of additional information... 16. Another type of late entry is the use of a clarification note. This clarification note is written to avoid incorrect interpretation of information that has previously been documented...". No further information was provided.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F 867		12/18/23

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systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and

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implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least

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F 867	Continued From page 60 annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, clinical record reviews and facility documentation reviews, the facility failed to have a Quality Assurance and Performance Improvement (QAPI) program that monitored its performance and ensured that improvements were sustained, which had the ability to affect all Residents within the facility. The findings included: The facility staff and QAPI program failed to monitor its performance and correct identified deficiencies and sustain improvements within multiple areas, which had the potential to affect resident care and safety.	F 867	F867 1. The Quality Assurance Committee will meet and review the purpose and function of the Quality Assurance Performance Improvement Committee as well as review the ongoing issues regarding notice of discharge, PASARR, professional standards of nursing care, care and treatment of pressure ulcers, accident hazards, food preferences, quality of care, accuracy of audits, and ongoing monitoring for compliance. 2. Current Residents are potentially affected by the deficiency. 3. The RDCS will educate the	

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F 867	Continued From page 61 The facility had a standard recertification survey conducted 7/9/23-7/14/23. During that survey, the facility was cited for not being in compliance in multiple areas, to include but not limited to: notice of discharge, pre-admission screening assessment and resident review (PASRR), failure to following professional standards of nursing practice, care and treatment of pressure ulcers, accident hazards and upholding Resident's food preferences. Immediate Jeopardy was identified in the area of Quality of Care. The facility had submitted a plan of correction, which included the QAPI program conducting audits and monitoring for ongoing compliance. The facility then had a re-visit to the standard survey, conducted 8/29/23-8/30/23. This survey found the facility to have not achieved compliance and deficient practice was cited again, in these same areas, some cited at a level three, isolated, which indicated harm to a Resident, had resulted from the deficient practice. Again, the facility submitted a plan of correction that indicated the QAPI program would conduct audits and monitor for ongoing compliance. During this second re-visit, which was conducted 10/30/23-11/3/23, the facility was found to have not conducted accurate audits, and the ongoing monitoring had missed continued deficient practice in the areas of: notice of discharge, pre-admission screening assessment and resident review (PASRR), failure to following professional standards of nursing practice, care and treatment of pressure ulcers, accident hazards and upholding Resident's food preferences. During this survey, the facility was found to be in immediate jeopardy again in the areas of treatment and services to prevent and	F 867	Administrator and Director of Nursing on the appropriate functioning of the QAPI committee to include identifying issues and correcting repeat deficiencies. A new Medical Director will begin on December 14, 2023. 4. The Administrator will educate QAPI committee members on a weekly review of audits and ongoing monitoring to ensure compliance. The QAPI committee will continue to meet monthly to identify and address compliance as indicated. 5. Completion date: December 18, 2023	

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F 867	Continued From page 62	F 867		

heal pressure ulcers and free from accident hazards.

On 11/2/23 at 11:09 AM, an interview was conducted with the facility Administrator. When asked about the facility's QAPI program, he indicated that the team meets monthly, and outlines the survey findings during QA (Quality Assurance) based on the survey findings in the 2567 (survey finding/statement of deficiencies report) and monitors the audits conducted and if no one has questions we move on to the next topic. When asked specifically to describe the role of the QAPI committee and how they had failed to identify the continued areas of concern and implement systems to achieve compliance, he asked that he be given a moment and stepped out of the office. Upon the Administrator's return, he was accompanied by the Regional Director of Clinical Services (RDCS).

The question was asked again of the RDCS. The RDCS indicated that she attended the QAPI meetings on occasion but not every time. When asked how they had failed to identify the ongoing concerns and lack of compliance she indicated they had been monitoring and felt compliance was achieved but stated, "The QAPI process is an ongoing daily thing because our staff are human mistakes can happen, it is an ongoing focused process."

Review of the facility policy titled, "QAPI" with an effective date of 5/9/22, was conducted. Excerpts from this policy read, "...4. The center maintains center specific quality clinical and service indicators that re[sic] to be monitored and improved by the QAPI Committee if undesirable patterns or trends are established. The

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F 867	Continued From page 63 Administrator is responsible for overseeing the QAPI Committee's initiatives to sustain and/or improve quality outcomes of problems identified within his/her Center. 5. In addition to center establish [sic] indicators and surveys, the Administrator and the QAPI Committee are responsible for targeting and monitoring specific services and/or operational areas of on-going studies within the Center. These are identified as a priority for high risk, high volume, or problem prone processes, or value-added care or service relationships and/or opportunities for improving dimensions of performance...". On 11/2/23, the facility Administrator and Director of Nursing were made aware of concerns in regard to the QAPI Committee. No further information was provided.	F 867		
{F 908} SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation review, the facility staff failed to maintain all patient care equipment in safe operating condition for one Resident (#214) in a survey sample of 32 Residents. The findings included: For Resident # 214 the facility staff failed to use the bed equipment as per the manufacturer's instructions and guidelines.	{F 908}	F908 1. Resident #223□s mattress has been secured to the bed frame and he has been assessed to need no bed rails. 2. All Residents have the potential to be affected. All beds will be visualized to ensure that the mattress is secure. 3. All Nursing, Maintenance, and Housekeeping staff will be educated by the SDC/designee on ensuring that the	12/18/23

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{F 908}	Continued From page 64 On the morning of 10/30/23 Resident #223 was observed resting in bed with the mattress sliding off the side of the bed frame, the mattress was hanging over the edge about 3-4 inches. Upon closer inspection of the bed frame, it was discovered that there were no mattress retainers on the bed frame. The bed had no type of bed rails or other positioning device attached. On 10/31/23 at 1:00 PM Resident #223 was observed in bed resting with eyes closed with the bottom of mattress slightly hanging over the frame about 2-3 inches. On 10/31/23 at approximately 1:00 PM on an interview was conducted with RN C (registered nurse-C) who was asked about the overlap, and she stated that this does pose a problem if the Resident were to sit on the edge of the bed they could possibly slide to the floor since the mattress was not on the bed frame properly. On 11/1/23 at 2:00 PM observation was made of Resident #223 in bed resting with eyes closed and 1/2 rails were present on bed. On 11/1/23 at 2:15 PM a review of the clinical record revealed that Resident #223 had no side rail assessment, no orders and was not care planned for side rails. On 11/1/23 at 2:37 PM an interview was conducted with the maintenance director who stated that he was called by the Administrator to put siderails on Resident #223's bed. When asked why he stated, "They don't tell me why, all I know is they have to do an assessment and then whatever the reason the Resident needs a siderail they contact me, and I put the rail on and do an entrapment assessment." When asked if	{F 908}	bed mattress is secured to the bed frame. 4. The UM/designee will review mattress placement weekly times 4 and monthly times 2 to ensure that the mattress is not off the bed frame. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 908}	Continued From page 65	{F 908}		

this bed had mattress guards to keep the mattress from sliding off the bed he stated, "No, the bed is too old, it's a discontinued model."

On 11/1/23 at 3:00 PM an interview was conducted with the Administrator who stated that he spoke with someone from the company that manufactured the bed and was told that the bed was too old and there were no mattress stops and that they could use a bed rail to secure the mattress to the bed. When asked if he was saying that the bed rail was being used to secure the mattress to the bed, he stated that it was.

On 11/2/23 at 9:04 AM a phone call was placed to the manufacturer of the bed and when asked if this bed (Model 330 B) had mattress stops or guides to keep the mattress from sliding off the frame, the employee stated this is an old bedframe and it did not have built in mattress guides or stops at the time the bed was manufactured. The product support specialist for the manufacturer stated that "Mattress stops are available for sale as an accessory for the bed. When asked if the manufacturer would recommend using side rails to stop the mattress from sliding, he stated "It is the position of our company that side rails are used only for the needs of the Residents. The Resident must be evaluated, and it must be documented that they need the rails for positioning and as an assistive device. There are regulations that vary from state to state about using siderails as positioning devices, but they are NOT recommended to be used to secure a mattress in place to a bed. For securing the mattress our company has mattress stops available for purchase."

On 11/2/23 at 3:15 PM a policy for "Bed Rails"

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{F 908}	Continued From page 66 was requested and the surveyors were told there is no policy at the facility specific to bed rail use. A device policy was submitted to the survey team. A review of the facility policy read: "Policy Name: Medical Equipment" "Policy: Nursing will follow manufacturer's recommended guidelines on all medical equipment and clinical devices." On 11/2/23 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	{F 908}		
{F 925} SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain an effective pest control program in the kitchen and on one of two nursing units, which had the ability to affect many Residents. The findings included: 1. The facility staff failed to maintain the kitchen in a manner, and respond to the pest control company's recommendations, to control pests. On 10/30/23 at 1:04 PM, observations were made in the facility's kitchen. The dietary manager/Employee H accompanied Surveyor D in making observations. It was noted in the dish	{F 925}	F925 1. The kitchen and 2nd floor unit have a pest control program in place to manage the presence of pests. 2. All Residents have the potential to be affected. Pest control services are being provided to the facility common areas, storage areas, and Resident rooms twice weekly. 3. Dietary staff will be educated on keeping the outside door closed, management of food and grease debris, and reporting needed repairs. Closed containers will be provided to Residents who prefer to keep opened food items in	12/18/23

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{F 925}	Continued From page 67 room that under the dish machine and sink there was broken floor files, an abundance of food on the floor and a copious amount of small gnat sized pests flying around. Employee H, the dietary manager confirmed the observations. On 10/30/23 at 1;15 PM, an interview was conducted with Employee J, a cook. When asked about the flying pests, Employee J said, "We see them, but we spray each night to clean." On 10/30/23 at approximately 2 PM, an interview was conducted with the pest control company's service technician. When asked about pests in the facility, he said, "I do the best I can, but they have to meet me halfway. When I came in today, the back door to the kitchen was wide open. I have told them of things that need to be fixed in the kitchen, I'm to the point of just fixing it myself and sending them the bill". When asked if he has had issues with small gnat sized pests, he indicated he has and that without proper cleaning he can only do so much. On 10/31/23, a review was conducted of the pest control service reports. The report from the visit on 10/30/23, read, "... slime and food/grease build up behind oven, drink and ice machine, freezer, under and between floor tiles and around wall in dish room, ice machine still draining outside of drain, mop sink on loading dock has food and grease debris and back door is open." The pest control report from 10/26/23, read, "... baited kitchen and dishwashing room for fruit flies. Ice machine drain tube not draining in drain- keeps getting knocked off. Back door needs to be kept closed, floor tiles need to be repaired in dish room, water and food debris	{F 925}	their rooms. 4. The Administrator/designee will monitor pest control logs, kitchen, and 2nd floor unit for management of pest control weekly times 4 and monthly times 2. Results of the review will be presented to the Quality Assurance Committee monthly times 2. 5. Completion date: December 18, 2023	

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{F 925}	Continued From page 68 needs to be cleaned up daily." The pest control report from 10/16/23, read, "... Starting 10/16/23 weekly visits on 1st, 2nd, 3rd, 4th Monday monthly until problem is resolved. Cooperation from staff is essential for control/ there will be an added charge for the fruit flies and fungus gnat treatments... Pooling water behind equipment needs rectified, tile replaced/walls, pipe, cords need cleaning in kitchen..." On 10/31/23 at 1:45 PM, observations were made again in the kitchen. The floor tiles were still noted to be broken under the dish machine which left standing water, where the tile should be. There were still copious amounts of food under the sink in the dish room. When the dietary manager was asked about the cleaning of the area, she said, "It is hard to get to with all those pipes." Surveyor D noted a utensil in the floor under the sink that had been observed on the day prior. There was still flying pests noted but fewer than the day prior. When asked what they had done, the Dietary manager said, "We sprayed it down last night and the pest guy put some stuff in there [referring to the drain]." 2. The facility staff failed to maintain the environment in a manner for the pest control to be effective in control of ants on one Resident unit. On 10/30/23, the pest control log on the 2nd floor was reviewed. This document noted that Room [room number redacted] was noted on 10/24/23 and 10/25/23, to have "ants on bedside table."	{F 925}		

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{F 925}	Continued From page 69	{F 925}		

On 10/30/23 at 1:20 PM, Resident #207 was visited by Surveyor D and observations were made of the room. It was noted that there was a trail of ants across the floor by the bedside table. There was food debris noted on the floor under the bed.

On 10/30/23 at 1:35 PM, an interview was conducted with CNA B (certified nursing assistant-B). CNA B was asked about pests, and she reported she sees a lot of ants. She added that she knows they have a pest control company that comes but she was not sure how often.

On 10/30/23 at approximately 2 PM, an interview was conducted with the pest control company's service technician. When asked about the pests within the facility, the technician said that ants have been an ongoing issue in a particular area. When asked if the hall where Resident #207's room is, is the problem area, he indicated it was. The pest control tech. accompanied Surveyor D to Resident #207's room.

The pest control tech. confirmed the trail of ants crawling on the floor under and around the bed of Resident #207. The pest control tech opened the drawers to the bedside table and noted no food items in the cabinet, just the debris on the floor. He then lifted the fall mat that was at the bedside, and it was saturated wet under the fall mat. He noted an abundance of ants under the mat as well and commented that without proper cleaning, his chemicals will only work so well.

During the end of day meeting held on 10/30/23 at 5:30 PM, the facility Administrator and Director of Nursing were made aware of the above concerns and the pest control policy was

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{F 925}	Continued From page 70 requested. On 10/31/23, the facility provided the policy titled, "Pest Control" with an effective date of 5/1/22. The policy read, "1. Observe and document sightings of pests in the contractor/pest sighting logbook maintained at each nursing station. 2. Notify service vendor of sightings. 3. Verify vendor provides services as outlined in the [company name redacted] corporate-approved service agreement.... 5. Complete documentation as outlined in the preventive maintenance electronic record". No further information was provided.	{F 925}		