STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CHESAPEAKE	715 ARGYLL ST CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/05/23 through 12/08/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 12/05/23 through 12/08/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Ten complaints were investigated during the survey: VA00048704 Substantiated (Sub), no deficiency; VA00049344 Sub, with deficiency; VA00049591 Sub, with deficiency; VA00052041 Unsubstantiated (Unsub), lack of sufficient evidence; VA00052410 Unsubstantiated, lack of sufficient evidence; VA00053928 Unsubstantiated, lack of sufficient evidence; VA00056601 Sub, with deficiency; VA00057812 Unsubstantiated, lack of sufficient evidence; VA00059167 Sub, with deficiency; VA00059193. The census in this 117-certified-bed facility was 105 at the time of the survey. The survey sample consisted of 55 resident reviews.	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/12/24

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

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F 554	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to assess and determine if a Resident was safe to self-administer medications that were at the bedside, for six Residents (Resident #42, 54, 77, 51, 78 and #7) in a survey sample of 55 Residents. The findings included: 1. For Residents #42, 54, 77, 51, and 78, all of whom had medications stored in their room, the facility staff failed to assess if the Residents were safe to self-administer medications. On 12/5/23 at approximately 12:00 PM, observations were conducted of the 100 unit. Multiple Residents were noted to have over the counter medications at the bedside. They included: a. Resident #42 had hair growth pills/supplement at bedside. b. Resident #54 had Nutririte-800 multivitamins on the bedside table. The Resident said he takes 2 once a day, and reports he got them from dialysis and has been taking them about a year. c. Resident #77 had refresh lubricating eye drops at the bedside and hemorrhoid cream in the bathroom. d. Resident #51 had a tube of hydrocolloid cream and a bottle of Sarna anti-itch cream on the bedside table. The Sarna lotion had a	F 554	F 554 1. The facility failed to assess 6 residents (#42, 54, 77, 51, 78 and #7) for self- administration as evidenced by 6 residents having meds found at bedside during observational rounds. All resident medication were immediately removed from bedside. All residents were immediately reassessed to be unable to safely self-administer medications. 2. 100% of residents have the potential to be affected, A 100% completion of self- administration assessments on all current residents will be conducted by DON/ and or designee. Resident's assessed as safe to appropriately self- administer medications will have plan of care updated and provided safe storage for medications. 3. 100% of all licensed nursing staff were educated by the DON/ and or desginee on the facilities resident self-administration policy. 4. The DON and/or designee will complete self- administration audits on all new admissions and reassess all current residents quarterly based on the MDS Careplan schedule for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation 5. Completed on 1/19/2024.	

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prescription label, which indicated it belonged to Resident #394. Per the clinical record and an interview with CNA #1, Resident #394 had expired on 11/10/23.

e. Resident #78 had refresh eye drops with a prescription label and a container of roll-on bio freeze at the bedside. On 12/6/23, at approximately 1 PM, an additional observation was made of Resident #78's room. The bio freeze was still noted to be at the bedside.

On 12/05/23 at 02:14 PM, an interview was conducted with LPN #5. LPN #5 stated that all medications must be kept locked in the medication cart or medication room. When asked if medications can be kept in the Resident rooms, LPN #5 said, "They should not keep meds in room, but it is based on their BIMS (brief interview for mental status) score. They have to score over a certain thing, to even be considered. Being a nursing home though we don't keep medications in the rooms. We have had people where families are non-complaint and go against what we ask, so if we find something we take it and notify the DON (Director of Nursing) and unit manager.

Following the above interview with LPN #5, LPN #5 accompanied the surveyors to Resident #78 and #77's room. LPN #5 confirmed the observations and removed the eye drops and hemorrhoid cream from Resident #77's room. LPN #5 also removed the eye drops from Resident #78's room but left the bio freeze. LPN #5 went on to say that they have difficulty with Resident #78 and her family with bringing items in. The surveyor explained that the items were easily identified upon observation and did not

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require that the Resident's personal items be inspected to locate the items. LPN #5 agreed that the items were easily identified and should have been removed by facility staff.

On 12/5/23-12/6/23, clinical record reviews were conducted of each of the Resident's charts. The findings were as follows:

a. Resident #42 had no assessment to determine if he/she was safe to self-administer medications. The care plan did not identify that the Resident was able to self-administer medications and keep them at the bedside. The physician orders did not include an order for any hair growth supplements.

b. Resident #54's clinical record revealed no current physician order for a multi-vitamin supplement. On 12/5/23 at 5:26 PM, a progress note was entered into the record that read, "This nurse in to eval resident for self-administration of Multivitamin. Pt has BIMS of 14 however pt has a d/x of major depressive and per facility assessment resident is unable to self-administer meds. Pt educated on self-administering meds along with the risks associated with doing this without nurse and MD being aware due to possible interactions with already prescribed meds being administered by nurse. Pt verbalized understanding".

c. Resident #77's physician orders revealed an order dated 10/4/22, that read, "Hemorrhoidal Relief Cream 5 % (Lidocaine (Anorectal)) Apply to rectum topically as needed for hemorrhoids apply to rectum as needed". On 6/14/23, an order was entered that read, "Refresh Tears Solution (Carboxymethylcellulose Sodium) Instill 1 drop in right eye two times a day for dry eye

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syndrome". On 12/5/23 at 5:22 PM, the facility staff conducted an assessment to determine if Resident #77 could self-administer medications. The assessment identified that since Resident #77 had a diagnosis of dementia, they were not a candidate.

d. Review of Resident #51's chart revealed that the Resident had not been assessed for the ability to self-administer medication.

e. Resident #78 was assessed by facility staff for the ability to self-administer medications on 12/5/23 at 5:24 PM. The Resident was noted to not be a candidate. The Resident had not been previously assessed prior to being permitted to have medications at the bedside and had no physician order for the bio freeze.

On 12/6/23 at 3:00 PM, an interview was conducted with the Director of Nursing (DON). The DON confirmed that many of the Residents had assessments conducted the evening prior in response to the items found by the surveyors in the Resident's rooms.

A review was conducted of the facility policy titled, "Self-Administration of Medication". Excerpts from the policy read, "1. Verify physician's order in the resident's chart for self-administration of specific medications under consideration. 2. Complete the Self-Administration of Medications Assessment with the resident... 4. If the interdisciplinary Team has determined the resident safe to administer medication(s), administration of medication(s) will be Care Planned for approved self-administered medications... 6. When a resident is unable to self-administer medications, the medication will

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F 554	Continued From page 5 be held by the nurses until the resident can be reassessed by the Interdisciplinary Team. 7... Medication(s) kept at the bedside must be kept in a locked drawer". On 12/6/23, in the late afternoon, the facility Administrator was made aware of the above findings. No further information was provided. 2. The facility staff failed to reassess Resident #7 for self-application of medication Hydrocortisone external cream 1 percent (%). Resident #7 was admitted to the facility on 11/30/22. Diagnosis for Resident #7 included but not limited to major depressive disorder. Resident #7's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 09/14/23, under cognitive status was not coded on the Brief Interview for Mental Status (BIMS) but was coded as independent for decisions being consistent and reasonable. The care plan with a created on 12/01/22 and a revision date of 10/27/23 identified Resident #7 on antidepressant therapy. The goal set for the resident by the staff to remain free from discomfort or adverse effects of antidepressant therapy. Some of the interventions/approaches the staff would use to accomplish this goal is administer antidepressant medication as prescribed by the physician, and consult with pharmacist, MD, medical director for gradual dose reduction if appropriate and monitor for side effects of antidepressant medications, e.g., suicidal ideations.	F 554		

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F 554	Continued From page 6 During the initial tour of the facility on 12/05/23 at approximately 1:59 p.m., observed on Resident #7's overbed table was an open tube of hydrocortisone cream 1%. The resident stated she has a rash to her upper arms, upper back and under her breast. She stated the cream dries up the rash and stops her skin from itching. She stated the hydrocortisone cream had been in her room for a while. A review of Resident #7's December 2023, Medication Administration Record (MAR) revealed the following order: Hydrocortisone External Cream 1 %, apply to chest, and arms topically every 4 hours as needed for itching starting on 11/14/23. A Self-Administration medication assessment was completed on 09/06/23 and 12/06/23 documented the resident did not wish to self-administer her own medications. An interview was conducted with the Unit Manager on 12/08/23 at 10:07 a.m. She stated she had removed the hydrocortisone cream out of Resident #7's room. She stated the cream at beside was a house stock cream. She stated the nurse probably applied the mediation but forgot to remove it from the resident's room. An interview was conducted with the Director of Nursing (DON) on 12/08/23 at 11:15 a.m., who stated Resident #7 had a self-administration assessment completed this morning and did not pass. She stated Resident #7 has a diagnosis of depression and with a diagnosis of depression who cannot self-administer your own medication.	F 554		

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A final meeting was held with the Administrator, Director of Nursing, and Regional Director of Clinical Services on 12/08/23 at 1:30 p.m., who were informed of the above findings. No further information was provided prior to exit.

The facility policy titled Self-Administration of Medication with a revision date of 11/28/23. Residents who have the desire to, and who have been assessed to be capable and safe to, may self-administer medications.

Procedure read in part:
1. Verify physician's order in the resident's chart for self-administration of specific medications under considerations.
4. If the Interdisciplinary Team (IDT) has determined the resident safe to administer medication(s), administration of medication(s) will be care planned for approved self-administered medication.
5. Self-administration of medications must be reviewed by the (IDT) with each quarterly review.
6. When a resident is unable to self-administer medications, the medication will be held by the nurse until the resident can be reassessed by the (IDT).
7. The MAR must identity medications that are self-administered, and the medication nurse will need to follow-up with the resident as the documentation and storage of medications during each medication pass. Medication(s) kept at the bedside must be kept in a locked drawer.

Definitions:
-Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body

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F 554	Continued From page 8 works (https://medlineplus.gov/ency/article/000945.htm). -Hydrocortisone cream is used to treat redness, swelling, itching, and discomfort of various skin conditions. It works by activating natural substances in the skin to reduce swelling, redness, and itching (https://medlineplus.gov/ency/article/000945.htm).	F 554		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for one of fifty five residents in the survey sample (Resident # 62). The findings include: Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. R62 was admitted with diagnoses that included alzhiemers, depression, dementia with psychotic disturbance, auditory hallucinations and epilepsy. The MDS daated 6/7/23 assessed R62 as being cognitively intact. R62's clinical record documented a MDS dated 9/7/23. Sections C0200, C0300, CO400 and CO500 were blank.	F 641	F 641 1. Facility failed to ensure an accurate minimum data set assessment for 1 resident (#62), cognitive assessment immediately corrected for affected resident. 2. 100% of residents have the potential to be affected, A 100% audit of all current residents verifying accurate completion of cognitive assessment completed on most recent MDS will be completed by the facility MDS Coordinator and/or Director of Nursing. 3. 100% of all MDS nurses, Social Service Director, and Speech Therapist, educated by DON or designee on the accurate completion of cognitive assessment within the MDS. 4. MDS and/or designee will conduct for audit completion of all cognitive assessment for all new residents and current residents based on the MDS Careplan schedule weekly for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 1/19/2024	

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F 641	Continued From page 9 On 12/7/23 at 9:12 am, the licensed practical nurse MDS coordinator (LPN#4) responsible for completing the MDS was interviewed about R62's incomplete MDS. LPN#4 stated that social services usually completed section C and we help them. LPN#4 also stated the assessment was not completed during the look back period and it got missed. The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Chapter 3 page C-2 documents steps for coding mental statusas, "Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) ..." (1) On 12/8/23 at 9:45 am these findings were reviewed with the administor, director of nursing and the regional nurse consultant with no further information presented. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, Centers for Medicare & Medicaid Services, Revised October 2023.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		

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F 656	Continued From page 10 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review,	F 656	F 656 1. Facility failed to implement care plan interventions for one resident (#5). Mattress was immediately placed in proper position beside bed. 2. 100% of residents have the potential to be affected, 100% of current residents audited for accurate fall careplan interventions in place. 3. 100% of all licensed nurses educated by DON or designee on completion of fall careplans and ensuring interventions. 4. MDS and Fall committee to complete audit of all falls weekly for 12 weeks to ensure fall interventions careplanned. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 1/19/2024.	

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F 656	Continued From page 11 the facility staff failed to implement care plan interventions for one Resident (Resident #5) in a survey sample of 55 Residents. The findings included: For Resident #5 the facility staff failed to ensure a mattress was at the immediate bedside of the Resident as identified in the care plan as a fall intervention to prevent injury. On 12/5/23 at approximately 12:30 PM, Resident #5 was observed lying in bed. In the room there was an additional mattress noted on the floor, but it was pushed mid-way of the room and not positioned beside the bed. On 12/7/23 at 8:33 AM., Resident #5 was observed again, lying in bed. The additional mattress was noted to be lying on the floor, but not by the bed, it was placed mid-way of the room between the bed and wall. On 12/7/23 at 8:35 AM, an interview was conducted with LPN #7, who is an MDS (minimum data set) nurse. When asked about the mattress in the floor, LPN #7 said it is to be positioned directly beside the bed as a fall precaution to "protect from injury". LPN #7 was asked to observe the mattress and she said, "They had to move it to clean in there, it was as if her catheter had leaked so housekeeping must have moved it". LPN #7 confirmed that it was to be directly beside the bed to prevent any injury if the Resident were to fall out of bed. On 12/7/23, a clinical record review was conducted. This review revealed Resident #5's care plan was reviewed and revised on 11/8/23.	F 656		

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F 656	Continued From page 12 One focus area read, "[Resident #5's name redacted] is at risk for fall r/t [related to] impaired mobility, impaired cognition. Resident also has behavior of placing self on floor". Interventions for this focus area included, "mattress to floor for comfort". On 12/7/23, in the late afternoon, the facility administration was made aware of the above findings. No further information was provided.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow standards of practice for two Residents (Resident #85 and #26) in a survey sample of 55 Residents. The findings included: 1. For Resident #85 the facility staff failed to follow standards of nursing practice by failing to implement physician orders to apply compression stockings in the morning for edema. Resident #85 has diagnosis of BLE (bilateral lower extremity) edema and CHF (congestive	F 658		

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F 658	Continued From page 13 heart failure), and compression hose ordered for edema to be put on in the morning and removed in the evening. On 12/6/23 in the morning and again in the afternoon, Resident #85 was observed sitting in her room and no compression stockings were on her BLE. On 12/7/23 after lunch, Resident #85 was observed sitting in a wheelchair in her room and she didn't have on compression stockings. On 12/8/23 in the morning, after breakfast, Resident #85 was observed in her room sitting in the bathroom in a wheelchair and no compression stockings were on her bilateral lower extremities. A clinical record review was conducted and revealed a physician order for compression hose to be put on in the morning and removed in the evening due to the resident's edema. A nurses note from LPN #6 on 12/7/23 stated that the Resident would apply after shower and on 12/8/23 states resident didn't want applied now and would check back later. On 12/6/23 at 2:00pm, an interview was conducted with Resident #85, resident stated that laundry took the hose and didn't return hose after being washed, so she is waiting on more to be ordered for her. On 12/7/23 at 10:34am, an interview was conducted with LPN #6, and she verbalized that compression hose are put on the resident in the mornings and she tried to put them on yesterday and "she disappeared off the unit".	F 658	F 658 1. Facility failed to follow standards of practice for two residents (#85 and #26). Resident #85 immediately received ordered ted hose. Education for nurse for resident #85 and #26 was educated on lidocaine patch process and medication documentation process and procedures for unavailable medications. 2. 100% of residents have the potential to be affected. A 100% audit has been conducted to ensure all residents with ted hose and lidocaine orders have them applied per resident compliance and doctors order. Nurse educated by DON on noted deficiencies 12/7/23. 3. 100% education of all licensed nursing staff regarding application of Ted hose and medication patches. 100% education on all licensed nurses on 5 rights of medication administration completed by DON or designee. 4. The DON or designee will complete audits of residents for medication at bedside and application of ordered ted hose and medication patches 5x weekly for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance Date 1/19/2024.	

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F 658	Continued From page 14 On 12/8/23 at 10:00am, Resident #85 was interviewed again. The resident was in her room and no compression hose were on her lower extremities, she stated she didn't receive hose until last night and staff applied hose at 7:00pm and removed at 9:00pm and staff is to apply this morning after her shower. Resident stated staff has to apply because she isn't able to put the hose on herself. The "Lippincott Manual of Nursing Practice", eighth edition, was reviewed. On page 18, in box 2-3, "Common Legal Claims for Departure from Standards of Care" were noted to include, but not limited to: ... " failure to perform a nursing treatment or procedure properly, ... failure to implement a physician/NP/PA order properly or in a timely fashion...". Administrator and DON made aware of findings on 12/7/23. No further information was provided prior to the conclusion of the survey. 2. For Resident #85, the facility staff failed to apply a lidocain patch to the correct location as ordered by the physician. On 12/6/23 at 8:22 AM, Resident #85 was observed and met during the survey teams observation of medication administration. it was noted that the Resident had a Lidcaine patch on her left posterior thigh. Following the medication administration observation, reconcilliation of physician orders	F 658		

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F 658	Continued From page 15 was conducted. During this review it was noted that Resident #85 had a physician order that read, "Lidoderm External Patch 5 % (Lidocaine) Apply to left lower back topically one time a day related to polyarthritis". The physician order stated to apply to the lower back, observations revealed it was applied to the thigh. On 12/6/23 at 9:04 AM, during an interview with Resident #85, it was noted that she had a lidocaine patch on her left posterior thigh. When asked about it, the Resident said she was unsure when it was put on but a nurse had applied it. On 12/06/23 at 09:08 AM, an interview was conducted with LPN #6. The LPN was asked about Resident #85's lidocaine patch and reported, "it is supposed to go on at bedtime and come off in the morning". When asked who takes it off, LPN #6 said, "the 11 p.m. -7 a.m. shift". When asked if the Resident is currently supposed to have one in place, the LPN said she was not. When asked if she had looked to verify this, LPN #6 said she had not looked even though it was visible to the surveyor during the medication administration observation conducted at 8:22 AM. Does she have one on, "I have not looked". On 12/06/23 at 09:11 AM, LPN #6 accompanied the surveyors to the Resident's room and confirmed the patch was not on the correct location and removed it. On 12/6/23, in the late afternoon, the facility Administration was made aware of the above findings and confirmed the facility follows Lippincott standards of nursing practice.	F 658		

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F 658	Continued From page 16 According to the "Lippincott Manual of Nursing Practice, Eighth Edition", "Common Legal Claims for Departure from Standards of Care" were listed on page 18. The list included, but was not limited to, "failure to administer medications properly and in a timely fashion...". 3. For Resident #26, the facility staff failed to follow standards of nursing practice, as evidenced by documenting that medications were administered that were not. On 12/6/23 at 8:16 AM, LPN #6 was observed to prepare and administer medications to Resident #26. During the medication administration observation, LPN #6 prepared the medications and provided Resident #26 with 4 medications, Coenzyme Q10 Capsule 100 MG, Coreg Tablet 12.5 MG (Carvedilol), Peridex Mouth/Throat Solution 0.12 % (Chlorhexidine Gluconate (Mouth-Throat), and boost (a nutritional supplement). Following the administration a record review was conducted to reconcile the administration. It was noted that LPN #6 had documented that Lasix Oral Tablet 20 MG (Furosemide), and MiraLAX Packet 17 GM (Polyethylene Glycol 3350) were administered when neither were given. On 12/6/23 at 9:12 AM, an interview was conducted with LPN #6. LPN #6 was asked about the medications documented as having been given during the 8:16 AM, medication administration that was observed by two surveyors. LPN #6 confirmed that Lasix and MiraLAX had not been given because they were	F 658		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	Continued From page 17 not available. When asked why they were documented as having been given, LPN #6 said, she was nervous. Another review of the clinical record revealed that LPN #6 had not documented that the medications were not administered, nor had it been indicated that the physician was made aware of the medications not being available. Review of the STAT box (emergency medication supply) contents listing revealed the Lasix was available in the STAT box and could have been retrieved to provide to the Resident. On 12/6/23 at 9:12 AM, an interview was conducted with LPN #6. LPN #6 was asked to explain the process if a medication is not available. LPN #6 said, if a medication is not available, she would check the emergency supply box (STAT box) and see if the medication was available to be obtained/retrieved there and if not would call the pharmacy and doctor. When asked if this process had been followed for Resident #85, she indicated it had not been done. The facility administration was asked to provide a copy of their facility policy regarding medication administration. The facility submitted an undated document titled, "Preparing for Medication Administration". Excerpts from this document read, "... Medications Administered: Initial appropriate book of the MAR immediately after administration of the medication. Medication Availability: If a medication is not administered because the medication is not available, make every effort to locate the medication. If the medication cannot be located, check the interim or emergency kit for the medication so that	F 658		

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F 658	Continued From page 18 medication pass can be completed. Document unavailable medications appropriately per facility protocol. Contact the pharmacy and arrange for delivery of the medication. On 12/6/23, in the later afternoon, the facility administration was made aware of the above observations and confirmed the facility follows Lippincott standards of nursing practice. According to the "Lippincott Manual of Nursing Practice, Eighth Edition", "Common Legal Claims for Departure from Standards of Care" were listed on page 18. The list included, but was not limited to, "failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately...". On 12/8/23, the facility Administrator provided the survey team with evidence that LPN #6 had received disciplinary action on 12/7/23 and was suspended pending an investigation. Additionally, the facility administration had provided education to LPN #6 regarding medication administration following them being made aware of the above findings. No further information was received.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff	F 677		

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F 677	Continued From page 19 interview, and clinical record review, the facility staff failed to respond to a Resident's request for ADL (activity of daily living) assistance for one Resident (Resident #48) in a survey sample of 55 Residents. The findings included: For Resident #48, the facility staff failed to respond to the Resident ringing the tap bell for an hour and a half to request assistance to bathe/wash up. On 12/6/23 at approximately 10:05-10:10 AM, Resident #48 was observed to be ringing her tap bell. The surveyor remained on the unit making ongoing observations and noted no staff entered to respond to the resident. Throughout this time, Resident #48 was ringing the bell. At approximately 11:20 AM, Resident #48 began banging profusely on the bell. On 12/6/23 at 11:29 AM, Resident #48 was asked by the surveyor what she needed and reported she had been waiting for staff to assist her with getting washed up. The Resident reported that this happens frequently that people don't come. She said she has waited as long as 3 hours because some people say they didn't hear the bell. During the above observations, LPN #6 was observed sitting at the nursing station working on the computer and various other staff members were observed on the nursing unit. Review of Resident #48's clinical record revealed that according to her ADL (activities of daily living) records and care plan, she required assistance of	F 677	F 677 1. Facility failed to answer call bell timely for ADL assistance for 1 resident (#48), facility immediately ensured that affected resident received ADL care 2. 100% of residents have the potential to be affected. Facility conducted interviews on 100% of all cognitive residents to address call bell response times. 3. 100% of all staff educated on call bell response times, acceptable call bell response time, routine rounding procedures, and ensuring call bells are within reach during routine care by DON and Administrator 4. The Facility Administrator or designee will conduct weekly audits of call light response times x5 weekly for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance Date 1/19/2024.	

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F 677	Continued From page 20 facility staff to complete her daily ADL's. A review was conducted of the facility's policy titled, "Resident Communication System and Call Light Policy". This policy read, "... 3. Staff will respond to call lights promptly". On the afternoon of 12/6/23, the facility's administration was made aware of the above findings. No further information was provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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, staff interview and clinical record review, the facility staff failed to maintain quality of care and ensure care was in accordance with the Resident's care plan, for two Residents (Resident #54 and #72), in a survey sample of 55 Residents. The findings included: For Resident #54 and #72, who were both on a fluid restriction, the facility staff failed to maintain the restrictions of the fluid restrictions by	F 684		

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F 684	Continued From page 21 providing water at the bedside. On 12/6/23 at approximately 10 AM, observations were made in Resident #54's room. Resident #54 was noted to have a water pitcher at the bedside which was 3/4 full of ice water. It was observed that on the wall behind the bed, a sign noted a 1000 cc fluid restriction. On 12/6/23 at approximately 10:21 AM, observations were made of Resident #72's room. On the over bed table there was a full water pitcher in his room, which contained approximately 960 cc., a 120-cc cup of juice was noted and another cup with approx. 120 cc of liquid was noted. A sign above bed says 1000 cc fluid restriction. On 12/7/23 at 8:23 AM, observations were made in Resident #54's room. He was noted to have a water pitcher on the over bed table which was 3/4 full of ice water. A canned 12-ounce diet coke on the bedside table. Resident #54 also receives medications where water is provided and is provided beverages with meals. By having the water pitcher and other fluids at the bedside, the 1000 cc fluid restriction per day is exceeded. Review of both Resident #54 and 72's care plan revealed they were both on a fluid restriction. There was no indication in the care plan that the Residents were non-compliant with the fluid restriction. Resident #54's physician order read, "1000ml fluid restriction: Dietary Breakfast 240ml, Lunch 120ml, Dinner 120ml==480ml total Nursing, A.M. 240ml, P.M. 220ml, NOC 60ml==520ml total every shift".	F 684	F 684 1. Facility failed to maintain fluid restriction for 2 residents (#54 and #72), affected resident immediately had pitchers removed from bedside. 2. 100% of residents with fluid restrictions have the potential to be affected. 100% of residents with fluid restrictions orders and careplans audited to ensure accuracy, by DON or designee. 3. 100% of all staff have been educated regarding the facility policy and procedure for residents with fluid restrictions by nursing home administrator. 100% of all food service staff educated on providing fluids per order for residents with fluid restrictions by dietician. 100% of nursing staff educated on providing fluids per order for residents with fluid restrictions by DON. 4. DON or designee will conduct audits on all residents with fluid restriction for visualization of interventions in place x 5 weekly for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation 5. Compliance Date 1/19/2024.	

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F 684	Continued From page 22 Resident #72's physician order read, "1000ml Fluid restriction Dietary Breakfast=240cc, Lunch=240cc, dinner=240cc Total=720ml Nursing AM=120cc, PM=120cc, NOC=40cc Total=280ml every shift". On 12/7/23 at approximately 8:40 AM, an interview was conducted with LPN #6. When asked about the two Residents being on fluid restrictions, she confirmed they were both on fluid restrictions. When asked about the water pitcher being at the bedside and asked how they maintained the fluid restriction, LPN #6 said, she was not sure and perhaps the water pitcher was there just as facility protocol. On 12/7/23, in the late afternoon, the facility administration was made aware of the above findings. No further information was provided.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to maintain a safe environment, free of accident	F 689		

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F 689	Continued From page 23 hazards on one of four Resident care units. The findings included: On the one hundred nursing unit, the facility failed to secure medications and chemicals to maintain a safe environment, free of accident hazards. 1a. On 12/5/23 at approximately 12:00 PM, observations were conducted of the 100 unit. Multiple Residents were noted to have over the counter medications at the bedside. They included: a. Resident #42 had hair growth pills/supplement at bedside. b. Resident #54 had Nutririte-800 multivitamins on the bedside table. c. Resident #77 had refresh lubricating eye drops at the bedside and hemorrhoid cream in the bathroom. d. Resident #51 had a tube of hydrocolloid cream and a bottle of Sarna anti-itch cream on the bedside table. The Sarna lotion had a prescription label, which indicated it belonged to Resident #394. Per the clinical record and an interview with CNA #1, Resident #394 had expired on 11/10/23. e. Resident #78 had refresh eye drops with a prescription label and a container of roll-on bio freeze at the bedside. On 12/6/23, at approximately 1 PM, an additional observation was made of Resident #78's room. The bio freeze was still noted to be at the bedside. On 12/05/23 at 02:14 PM, an interview was conducted with LPN #5. LPN #5 stated that all medications must be kept locked in the medication cart or medication room. When	F 689	F 689 1. Facility failed to maintain a safe environment, free of accident hazards on one of four resident care units, including secure medications and chemicals. All medications and chemical bottle immediately removed from unit and secured. 2. 100% of residents have the potential to be affected. All environmental services staff educated on chemical spray bottle labeling on 12/6/23. 100% audit conducted to ensure appropriate medication storage by the DON or designee. 100% of residents rooms audited for unsecure medications and cleaning chemicals. 3. 100% of all licensed nurses educated on proper medication storage completed by DON or designee, 100% of interdisciplinary team educated on facility rounding and reporting procedure for any meds or chemicals not stored properly. 4. Interdisciplinary team will conduct audits within facility to ensure no medication or chemicals within resident rooms 5 x weekly for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance Date: 1/19/2024	

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F 689	Continued From page 24 asked if medications can be kept in the Resident rooms, LPN #5 said, "They should not keep meds in room, but it is based on their BIMS (brief interview for mental status) score. They must score over a certain thing, to even be considered. Being a nursing home though we don't keep medications in the rooms. We have had people where families are non-complaint and go against what we ask, so if we find something we take it and notify the DON (Director of Nursing) and unit manager. Following the above interview with LPN #5, LPN #5 accompanied the surveyors to Resident #78 and #77's room. LPN #5 confirmed the observations and removed the eye drops and hemorrhoid cream from Resident #77's room. LPN #5 also removed the eye drops from Resident #78's room but left the bio freeze. LPN #5 went on to say that they have difficulty with Resident #78 and her family with bringing items in. The surveyor explained that the items were easily identified upon observation and did not require that the Resident's personal items be inspected to locate the items. LPN #5 agreed that the items were easily identified and should have been removed by facility staff. The facility provided an undated document titled, "Medication Storage". Excerpts from this document read, "Proper medication storage is a standard of practice... Medication Carts: ... Medication carts and cabinets should be locked when unattended...". 1b. On 12/5/23 at approximately 12:30 PM, the following was observed on the 100 unit.	F 689		

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F 689	Continued From page 25 Resident #85 had a bottle of Lysol spray at her bedside. In Resident #17's bathroom, which was in her room, there was a spray bottle of cleaning chemical that was green in color. The bottle had no label. On 12/05/23 at 02:10 PM, an interview was conducted with Other Employee #2, who was a housekeeper. The housekeeper explained that all chemicals are to be kept in the locked portion of the housekeeping cart. Other Employee #2, then proceeded to show the two surveyors that the cart lock was broken so she was not able to lock it. When asked why chemicals must be locked, the employee said, "because patients can get to them, and it can be dangerous". On 12/5/23 at 3:40 PM, an interview was conducted with the Maintenance/Housekeeping Director (Other Employee #3). The unlabeled bottle with the cleaning chemicals was noted to be in his office. When asked if it is ok to leave chemicals in the Resident's room, he said, "100 percent no". When asked if the bottle was to have a label, he said, "Yes that is an OSHA issue, that's not normal for us". On 12/07/23 at 02:54 PM, an interview was conducted with CNA #2. CNA #2 confirmed that on the 100 unit they have 3 Residents who wander and self-propel in their wheelchairs. When asked if they go into other Resident rooms, CNA #2 said yes. A review was conducted of the facility policy titled, "Hazard Communication Program Policy". Excerpts from the policy read, "...making sure that hazardous chemicals and substances have an HMIS type label on it before it is used in the	F 689		

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F 689	Continued From page 26 workplace. Applying a HIMS label (if necessary) to containers... The Employee is responsible for: ... following safe work methods and safety rules...". On 12/6/23, in the late afternoon, the facility Administrator was made aware of the above findings. No further information was provided.	F 689		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the Payroll Based Journal (PBJ) Staffing Data Report, review of the actual working schedules for nurse staff, and staff interviews, the facility staff failed to ensure they had a Registered Nurse (RN) providing services at least eight consecutive hours within each twenty-four hour period, 7 days a week. The findings included:	F 727		

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F 727	Continued From page 27 The Fiscal Year Quarter 4 2023 (July 1 - September 30) PBJ Staffing Data Report triggered for four or more days within the quarter with no RN hours. A review of eleven months of actual nurse staffing from January 2023 through November 2023 revealed the facility was without an RN on duty eight consecutive hours on 2/12/23, 2/18/23 2/19/23, 3/4/23, 3/11/23, 3/19/23, 4/29/23, 7/9/23, 7/22/23, 7/23/23, 9/3/23, 9/9/23, 9/16/23, 9/30/23, 10/1/23, 10/14/23, 10/15/23, 11/23/23. On 12/7/23 at approximately 4:45 PM an interview was conducted with Licensed Practical Nurse (LPN) #11. LPN #11 stated a great deal of effort is expended to obtain RN coverage for the weekends and holidays but it is very challenging and occasionally they are not successful in meeting the requirement to have an RN on duty for eight consecutive hours every twenty-four hours. LPN #11 also stated many times the RN is scheduled, but calls out therefore the facility is without the supervision of the RN. The review also identified that many days in which RN coverage was not available it was because an RN had not been scheduled to work for eight consecutive hours within each twenty-four hour period Since a lack of RN coverage was identified for four or more days in quarters two and four, and already for quarter one which will end 1/1/2024, random days without RN coverage were reviewed for the potential for more than minimal harm due to the facility's RN staffing failure. The review failured to identify specific services could not be provided when an RN was not available for eight consecutive hours within each twenty-four hour	F 727	F 727 1. Facility failed to provide required 8 consecutive RN hours for 18 days over last year 2. 100% of residents have the potential to be affected, A 100% audit was completed for last 30 days to ensure that 8 hours of consecutive RN hours are provided each day. 3. 100% of nursing leadership and scheduler educated on requirement to ensure 8 hours of RN coverage in the facility each day by the nursing home administrator. 4. Administrator or designee will conduct audit on RN coverage scheduled for each day of the week and will confirm 8 hours of consecutive RN hours scheduled daily for 12 weeks. 5. Compliance Date 1/19/2024.	

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F 727	Continued From page 28 period. On 8/21/23 at approximately 3:20 p.m., a final interview was conducted with the Administrator, Director of Nursing and two Corporate Consultants. The DON acknowledged the noncompliance but offered no additional information regarding a strategy to become compliant with RN staffing and the facility's team voiced no concerns regarding the above information.	F 727		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		

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F 755	Continued From page 29 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on a medication pass observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration to three (3) of 55 residents in the survey sample (Resident #69, #26, #85) and during a medication pass on one of four units (100 unit). The findings include: 1. Resident #69's medication Janumet was not available for administration resulting in five missed doses of the medication. Resident #69 (R69) was admitted to the facility with diagnoses that included diabetes, cerebral infarction, dysarthria, hypertension, protein-calorie malnutrition and dysphagia. The minimum data set (MDS) dated 11/6/23 assessed R69 as cognitively intact. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication Janumet 50-1000 mg (milligrams) one tablet by mouth two times per day for type 2 diabetes. A physician's order was documented on 11/2/23 for Janumet 50-1000 mg two times per day via gastric tube for management of type 2 diabetes. Resident #69's medication administration record	F 755	F 755 1. Facility failed to provide medication ordered for three residents (#69, #26, and #85) resident Resident #69 discharged on 7/30/22, resident #26 was given both medications that day and resident #85 given liquid iron from house stock and peridox ordered through pharmacy and given on 12/7/23. LPN responsible for residents #26 and #85 educated on 12/7/23 on medication administration and policy and procedure on unavailable medications. 2. 100% of residents have the potential to be affected, 100% audit completed of all medication ordered in stock and available by DON or designee. 3. 100% of all licensed nursing staff educated regarding medication availability, utilization of stat box, and process to follow when medication is unavailable. 4. DON or designee will conduct audits weekly for 12 weeks of all medication carts to ensure medication availability. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 1/19/2024.	

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F 755	Continued From page 30 (MAR) documented the 9:00 a.m. dose of Janumet was not administered on 9/6/23 and the 9:00 a.m. and 5:00 p.m. doses were not administered on 9/7/23. The December 2023 MAR documented the Janumet was not administered on 12/2/23 at 9:00 p.m. and on 12/3/23 at 9:00 a.m. A nursing note dated 9/6/23 documented R69's Janumet was not administered because the drug was not available from the pharmacy. A nurse practitioner's note dated 9/10/23 documented, "...missed Janumet...Per nurse, Janumet not given for 2 days..." A nursing note dated 12/2/23 documented regarding the Janumet, "...hold per MD [physician] awaiting pharmacy to deliver..." and a note on 12/3/23 documented, "...On hold per MD until received from pharmacy..." On 12/6/23 at 9:37 a.m., the licensed practical nurse (LPN #1) caring for R69 was interviewed about the missed doses of Janumet. LPN #1 stated she sometimes experienced problems with timely deliveries from the pharmacy. LPN #1 stated she usually ordered refills on medicines when there were five or less doses on the supply card. LPN #1 stated she had reordered medications before and three days later, the medications had not been delivered. LPN #1 stated she was not sure why the Janumet was not available on 9/6/23, 9/7/23, 12/2/23 or 12/3/23. On 12/6/23 at 10:30 a.m., the unit manager (LPN #2) was interviewed about R69's unavailable Janumet. LPN #2 stated the pharmacy usually sent a 14-day supply of the Janumet and at times the pharmacy requested additional information about this prescription because it was expensive.	F 755		

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LPN #2 stated the Janumet was most recently reordered on 11/22/23 so she was not sure why it was not available on 12/2/23.

On 12/6/23 at 1:54 p.m., the unit manager (LPN #2) was interviewed again about R69's unavailable Janumet. LPN #2 stated the Janumet was not stocked in the back-up supply, so it had to be delivered from the pharmacy. LPN #2 stated nurses were expected to order medication refills several days in advance of running out.

On 12/7/23 at 3:04 p.m., the director of nursing (DON) was interviewed about R69's unavailable Janumet. The DON stated regarding the pharmacy deliveries, "We have problems at times." The DON stated the Janumet was not part of the back-up inventory. The DON stated nurses entered refill orders from the computer and were expected to reorder medicines at least two days in advance of running out to allow time for delivery.

On 12/7/23 at 5:55 p.m., the facility's consultant pharmacist (other staff #1) was interviewed about R69's unavailable Janumet doses. The pharmacist stated R69's insurance "did not like the medicine." The pharmacist stated sometimes a 14-day supply was provided and other times a 7-day supply was sent to the facility. The pharmacist stated Janumet had not been setup in the back-up inventory, and he was not sure if an alternate medication had been considered since there had been problems with keeping the Janumet in stock at the facility.

The facility's policy titled Medication Storage (undated) documented staff should ensure,

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F 755	Continued From page 32 "...Medication is available for all active resident orders..." The facility's training protocol titled Medication Storage and Labeling Critical Element Pathway (CMS for 20089) documented, "...Medications should be always available to be administered as ordered by following these steps: -Prompt re-ordering -Prompt receiving of medications - Prompt notification to provider or pharmacy if issue with medication order..." This finding was reviewed with the administrator and director of nursing during a meeting on 12/8/23 at 9:35 a.m. with no further information provided regarding the unavailable medication. 2. For Resident #26, the facility staff failed to ensure that medications were available for administration. On 12/6/23 at 8:16 AM, LPN #6 was observed to prepare and administer medications to Resident #26. LPN #6 administered 4 medications, Coenzyme Q10 Capsule 100 MG, Coreg Tablet 12.5 MG (Carvedilol), Peridex Mouth/Throat Solution 0.12 % (Chlorhexidine Gluconate (Mouth-Throat), and boost (a nutritional supplement). Following the administration a record review was conducted to reconcile the administration. It was noted that LPN #6 had documented that Lasix Oral Tablet 20 MG (Furosemide) and MiraLAX Packet 17 GM (Polyethylene Glycol 3350) were administered when neither were. On 12/6/23 at 9:04 AM, an interview was conducted with Resident #26. Resident #26 reported that at about 5 AM, she was given a few medications.	F 755		

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F 755	Continued From page 33 On 12/6/23 at 9:12 AM, an interview was conducted with LPN #6. LPN #6 was asked about the medications documented as having been given during the 8:16 AM, medication administration that was observed by two surveyors. LPN #6 confirmed that Lasix and MiraLAX had not been given because they were not available. When asked why they were documented as having been given, LPN #6 said, she was nervous. Another review of the clinical record revealed that LPN #6 had not documented that the medications were not available for administration, nor had it been indicated that the physician was made aware of the medications not being available. Review of the STAT box (emergency medication supply) contents listing revealed the Lasix was available in the STAT box and could have been retrieved to provide to the Resident. 3. For Resident #85, the facility staff failed to ensure that two medications were available for administration as ordered by the physician. On 12/6/23 at 8:22 AM, LPN #6 was observed during the preparation and administration of medications to Resident #85. It was noted that Resident #85 was given 9 medications. There were 2 medications, a liquid iron supplement and Peridex Mouth/Throat Solution that were not given. The iron supplement that was in the medication cart had expired November 2023, and therefore was not able to be administered and the Peridex mouth solution was not available. LPN #6 then continued her medication administration and moved on to the next resident	F 755		

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F 755	Continued From page 34 to administer medications. She made no efforts to take measures to obtain the medications or notify the provider that the medications were not available for administration. On 12/6/23 at approximately 9 AM, a clinical record review was conducted of Resident #85's chart. This review revealed no indication that the physician had been notified of the medication not being available nor the pharmacy being contacted to obtain/order the needed medications. On 12/6/23 at 9:12 AM, an interview was conducted with LPN #6. LPN #6 was asked to explain the process if a medication is not available. LPN #6 said, if a medication is not available, she would check the emergency supply box (STAT box) and see if the medication was available to be obtained/retrieved there and if not would call the pharmacy and doctor. When asked if this process had been followed for Resident #85, she indicated it had not been done. The facility administration was asked to provide a copy of their facility policy regarding medication administration. The facility submitted an undated document titled, "Preparing for Medication Administration". Excerpts from this document read, "... Medications Administered: Initial appropriate book of the MAR immediately after administration of the medication. Medication Availability: If a medication is not administered because the medication is not available, make every effort to locate the medication. If the medication cannot be located, check the interim or emergency kit for the medication so that medication pass can be completed. Document unavailable medications appropriately per facility protocol. Contact the pharmacy and arrange for	F 755		

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F 755	Continued From page 35 delivery of the medication. On 12/6/23, in the later afternoon, the facility administration was made aware of the above observations. On 12/8/23, the facility Administrator provided the survey team with evidence that LPN #6 had received disciplinary action on 12/7/23 and was suspended pending an investigation. Additionally, the facility administration had provided education to LPN #6 regarding medication administration following them being made aware of the above findings. No further information was received.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the medication error rate was less than 5%. There were 4 medication errors in 26 opportunities, affecting two (2) Residents (Resident #26 and #85), resulting in a 15.38% medication error rate. The findings included: On 12/6/23 at 8:16 AM, LPN #6 was observed to prepare and administer medications to Resident	F 759		

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F 759	Continued From page 36 #26 & at 8:22 AM, administered medications to Resident #85. During the medication administration observation, LPN #6 prepared the medications and provided Resident #26 with 4 medications, Coenzyme Q10 Capsule 100 MG, Coreg Tablet 12.5 MG (Carvedilol), Peridex Mouth/Throat Solution 0.12 % (Chlorhexidine Gluconate (Mouth-Throat), and boost (a nutritional supplement). Following the administration a record review was conducted to reconcile the administration. It was noted that LPN #6 had documented that Lasix Oral Tablet 20 MG (Furosemide), and MiraLAX Packet 17 GM (Polyethylene Glycol 3350) were administered when neither were given. On 12/6/23 at 9:12 AM, an interview was conducted with LPN #6. LPN #6 was asked about the medications documented as having been given during the 8:16 AM, medication administration that was observed by two surveyors. LPN #6 confirmed that Lasix and MiraLAX had not been given because they were not available. When asked why they were documented as having been given, LPN #6 said, she was nervous. Another review of the clinical record revealed that LPN #6 had not documented that the medications were not administered, nor had it been indicated that the physician was made aware of the medications not being available. Review of the STAT box (emergency medication supply) contents listing revealed the Lasix was available in the STAT box and could have been retrieved to provide to the Resident.	F 759	F 759 1. Upon med pass observations during annual inspection, the facility failed to ensure a med pass error rate of less than 5%. 2. 100% of residents have the potential to be affected, 100% of all license nurses will receive a Medication Administration Competency by the Director of Nursing and/or designee to ensure accurate medication administration. 3. 100% of all licensed nurses will be educated on the 5 Rights of Medication Administration and the facility Medication Administration protocol by the Director of Nursing 4. Director of Nursing or designee will conduct 5 Observational Medication Administration Competency's per week for 12 weeks. All aggregate findings will be submitted to the QAPI committee for review and recommendation. 5. Compliance date 1/19/2024.	

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F 759	Continued From page 37 On 12/6/23 at 8:22 AM, LPN #6 was observed during the preparation and administration of medications to Resident #85. It was noted that Resident #85 was given 9 medications. There were 2 medications, a liquid iron supplement and Peridex Mouth/Throat Solution that were not given. The iron supplement that was in the medication cart had expired November 2023, and therefore was not administered and the Peridex mouth solution was not available in the medication cart. LPN #6 then continued her medication administration and moved on to the next resident to administer medications. LPN #6 took no measures to obtain the medications by checking the emergency medication supply or calling the pharmacy and did not notify the provider that the medications were not available for administration to see if the provider had another alternative order to provide. On 12/6/23 at approximately 9 AM, a clinical record review was conducted of Resident #85's chart. This review revealed no indication that the physician had been notified of the medication not being available and not being administered nor the pharmacy being contacted to obtain/order the needed medications. On 12/6/23 at 9:12 AM, an interview was conducted with LPN #6. LPN #6 was asked to explain the process if a medication is not available. LPN #6 said, if a medication is not available, she would check the emergency supply box (STAT box) and see if the medication was available to be obtained/retrieved there and if not would call the pharmacy and doctor. When	F 759		

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F 759	Continued From page 38 asked if this process had been followed for Resident #85, she indicated it had not been done. The facility administration was asked to provide a copy of their facility policy regarding medication administration. The facility submitted an undated document titled, "Preparing for Medication Administration". Excerpts from this document read, "... Medications Administered: Initial appropriate book of the MAR immediately after administration of the medication. Medication Availability: If a medication is not administered because the medication is not available, make every effort to locate the medication. If the medication cannot be located, check the interim or emergency kit for the medication so that medication pass can be completed. Document unavailable medications appropriately per facility protocol. Contact the pharmacy and arrange for delivery of the medication. On 12/6/23, in the later afternoon, the facility administration was made aware of the above observations. On 12/8/23, the facility Administrator provided the survey team with evidence that LPN #6 had received disciplinary action on 12/7/23 and was suspended pending an investigation. Additionally, the facility administration had provided education to LPN #6 regarding medication administration following them being made aware of the above findings. No further information was received.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 39 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation review the facility staff failed to ensure medications were stored in a secured location, accessible to designated staff for 7 of 55 residents: Resident #7, Resident #85, Resident #42, Resident #54, Resident #77, Resident #51 and Resident #78 in the survey sample. The findings included: 1. The facility staff failed to ensure Hydrocortisone cream 1 percent (%) was stored	F 761	F 761 1. Facility failed to ensure proper medication storage for 7 residents (#7, #85, #42, #54, #77, #51, and #78), facility immediately ensured medication for both affected residents were moved to proper storage. 2. 100% of residents have the potential to be affected, 100% audit conducted to ensure appropriate medication storage by the DON or designee. 3. 100% of all licensed nurses educated on proper medication storage completed by DON or designee, 100% of interdisciplinary team educated on facility rounding and reporting procedure for any meds not stored properly. 4. DON or designee will conduct audits within facility to ensure medication stored safely and appropriately 5 x weekly for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation 5. Compliance date 1/19/2024.	

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F 761	Continued From page 40 in a secured location, accessible to designated staff only. Resident #7 was admitted to the facility on 11/30/22. Diagnosis for Resident #7 included but not limited to major depressive disorder. Resident #7's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 09/14/23, under cognitive status was not coded on the Brief Interview for Mental Status (BIMS) but was coded as independent for decisions being consistent and reasonable. During the initial tour of the facility on 12/05/23 at approximately 1:59 p.m., observed on Resident #7's overbed table was an open tube of hydrocortisone cream 1%. The resident stated applied the cream to a rash located to her upper arms, upper back, and under her breast. She stated the cream dries up the rash and stops her skin from itching. She stated the hydrocortisone cream had been in her room for a while. A review of Resident #7's December 2023, Medication Administration Record (MAR) revealed the following order: Hydrocortisone External Cream 1 %, apply to chest, and arms topically every 4 hours as needed for itching starting on 11/14/23. An interview was conducted with the Unit Manager on 12/08/23 at 10:07 a.m. She stated she removed the hydrocortisone cream out of Resident #7's room. She stated the cream at beside was a house stock cream and should have been locked in the treatment care and applied by the nurse.	F 761		

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F 761	Continued From page 41 An interview was conducted with the Director of Nursing (DON) on 12/08/23 at 11:15 a.m., who stated Resident #7 had a self-administration assessment completed this morning and did not pass. She stated Resident #7 has a diagnosis of depression and with a diagnosis of depression who cannot self-administer your own medication. She stated Resident #7's hydrocortisone cream should have been stored in the medication cart and applied by the nurse. A final meeting was held with the Administrator, Director of Nursing, and Regional Director of Clinical Services on 12/08/23 at 1:30 p.m., who were informed of the above findings. No further information was provided prior to exit. The facility provided a document titled Medication Storage. -Proper medication storage is a standard of practice. Definitions: -Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works (https://medlineplus.gov/ency/article/000945.htm). -Hydrocortisone cream is used to treat redness, swelling, itching, and discomfort of various skin conditions. It works by activating natural substances in the skin to reduce swelling, redness, and itching (https://medlineplus.gov/ency/article/000945.htm) 2. On the 100 unit, the facility staff failed to ensure expired medications were removed from	F 761		

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F 761	Continued From page 42 the medication cart and not available for administration. On 12/6/23 at 8:22 AM, observations were made with LPN #6, during medication administration. LPN #6 was preparing medications for Resident #85. When LPN #6 retrieved the liquid iron from the medication cart, she poured the dose into a disposable medicine cup and then checked the bottle. She noted that the iron expired November 2023. Upon identification of this, LPN #6 discarded the poured medication and placed the bottle in the bottom drawer of the medication cart. During the above observation, LPN #6 was interviewed. LPN #6 stated that expired medications are to be removed from the medication cart and discarded to ensure they are not given to Residents. Resident #85's orders and medication administration record were reviewed. This review revealed that Resident #85 had an order dated 11/4/23, that read, "Ferrous Sulfate Oral Solution (Ferrous Sulfate) Give 5 ml by mouth one time a day for Supplement". The medication administration record revealed that the medication had been signed off as being given/administered the 5 days prior. When LPN #6 was asked if the expired medication was given, she stated she didn't know but had no other supply to administer at this time. The facility administration was made aware of the above observation. The facility policy for medication storage was requested. The facility provided an undated document titled, "Medication Storage". Excerpts from this	F 761		

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F 761	Continued From page 43 document read, "Proper medication storage is a standard of practice... Medication Carts: ... Discontinued and/or expired medications should be removed from medication carts...". No further information was provided. 3. On the 100 unit of the facility, the facility staff failed to ensure medications were stored in a locked compartment and only authorized personnel had access. On 12/5/23 at approximately 12:00 PM, observations were conducted of the 100 unit. Multiple Residents were noted to have over the counter medications at the bedside. They included: a. Resident #42 had hair growth pills/supplement at bedside. b. Resident #54 had Nutririte-800 multivitamins on the bedside table. The Resident said he takes 2 once a day, and reports he got them from dialysis and has been taking them about a year. c. Resident #77 had refresh lubricating eye drops at the bedside and hemorrhoid cream in the bathroom. d. Resident #51 had a tube of hydrocolloid cream and a bottle of Sarna anti-itch cream on the bedside table. The Sarna lotion had a prescription label, which indicated it belonged to Resident #394. Per the clinical record and an interview with CNA #1, Resident #394 had expired on 11/10/23.	F 761		

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F 761	Continued From page 44 e. Resident #78 had refresh eye drops with a prescription label and a container of roll-on bio freeze at the bedside. On 12/6/23, at approximately 1 PM, an additional observation was made of Resident #78's room. The bio freeze was still noted to be at the bedside. On 12/05/23 at 02:14 PM, an interview was conducted with LPN #5. LPN #5 stated that all medications must be kept locked in the medication cart or medication room. When asked if medications can be kept in the Resident rooms, LPN #5 said, "They should not keep meds in room, but it is based on their BIMS (brief interview for mental status) score. They have to score over a certain thing, to even be considered. Being a nursing home though we don't keep medications in the rooms. We have had people where families are non-complaint and go against what we ask, so if we find something we take it and notify the DON (Director of Nursing) and unit manager. Following the above interview with LPN #5, LPN #5 accompanied the surveyors to Resident #78 and #77's room. LPN #5 confirmed the observations and removed the eye drops and hemorrhoid cream from Resident #77's room. LPN #5 also removed the eye drops from Resident #78's room but left the bio freeze. LPN #5 went on to say that they have difficulty with Resident #78 and her family with bringing items in. The surveyor explained that the items were easily identified upon observation and did not require that the Resident's personal items be inspected to locate the items. LPN #5 agreed that the items were easily identified and should have been removed by facility staff.	F 761		

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F 761	Continued From page 45 A review was conducted of the facility policy titled, "Self-Administration of Medication". Excerpts from the policy read, "... 6. When a resident is unable to self-administer medications, the medication will be held by the nurses until the resident can be reassessed by the Interdisciplinary Team. 7... Medication(s) kept at the bedside must be kept in a locked drawer". The facility provided an undated document titled, "Medication Storage". Excerpts from this document read, "Proper medication storage is a standard of practice... Medication Carts: ... Medication carts and cabinets should be locked when unattended...". On 12/6/23, in the late afternoon, the facility Administrator was made aware of the above findings.	F 761		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional	F 840		

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F 840	Continued From page 46 standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews and clinical record review, the facility staff failed to ensure transportation arrangements were made for 1 resident's dental appointment in a survey sample of 55 residents (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 11/29/13. The current diagnoses included cerebral palsy. The quarterly revised Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 09/07/23 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. In section"GG"(Physical functioning) the resident was coded as being dependent on staff for eating, oral hygiene, toileting, shower and bathing. The person centered care plan created on 8/03/21 read Resident #1 has a potential oral health problem. The goal set for the resident was they will have proper nutrition and hydration and will be free of pain or bleeding in the oral cavity. (revised on 12/23/22). Some of the interventions/approaches the staff would use to accomplish this goal was to assess oral cavity for pain, sensitivity, presence of lesions, ulcers,	F 840	F 840 1. Facility failed to provide transportation services for 1 resident (# 1), facility immediately ensured resident had transportation scheduled. 2. 100% of residents have the potential to be affected. 100% of current residents with appointments for the next two weeks scheduled audited to ensure transportation available. 3. 100% of nursing leadership, Social Service Director, and scheduler educated on process to schedule transportation. 4. Nursing home administrator to audit upcoming weekly appointments to ensure transportation in place for 12 weeks. Results of the weekly inspections will be submitted to the QAPI committee for review and recommendation. 5. Compliance Date 1/19/2024.	

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F 840	Continued From page 47 inflammation, bleeding, swelling or rashes, assist/provide mouth care as needed and referral to dental services (8/03/21). On 12/06/23 at approximately 11:00 a.m., during the initial tour Resident #1 was observed lying in bed in a supine position, appeared restless at times and making sounds. A specialty wheel chair was observed near the resident's bed. On 12/06/23 at approximately 12:32 p.m., a phone call was made to Family Member (FM) #1 concerning Resident #1. FM #1 said that Resident #1, has a lot of dental cavities. FM #1 said that he has mentioned this to the social worker (SW) and nurse at care plan meetings. The family member also said that he was concerned that the resident's teeth could be bothering her, but because she is non-verbal, pain may not be communicated to the facility staff. On 12/08/23 at approximately 12:50 p.m. an interview was conducted with Other Staff Member (OSM) #6. OSM #6 was asked by the surveyor if resident could receive a Medicaid Advantage Plus (MAP) adjustment to receive dental services. She said that Resident #1 didn't qualify for a MAP adjustment. She was then ask if resident could be transported via wheelchair transport. She said that she would check with the staff. An interview was conducted with the Director of Nursing (DON) and with Registered Nurse (RN), (Regional Clinical Nurse/RCN) #1 on 12/08/23 at approximately 2:10 p.m., concerning Resident #1 receiving transport services to the dental office. The DON said that the dental service could not accommodate the resident via stretcher in their	F 840		

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F 840	Continued From page 48 office. The following nurses' notes were received from RN #1 on 12/07/23 at 3:40 p.m., "A call made to Doctor of Dental Surgery (DDS) at 2:45 p.m., Message left was regarding if they take [Name of Medicaid service]. A call was placed at 3:20 p.m., to Dental Services office to ask if they accepted the above insurance. Received a returned call from the Dental Services office at 3:25 p.m. They do accept Medicaid and their VA Beach office can accommodate patient's specialty wheelchair in their office. Appointment scheduled for 1/05/24 at 2:00 p.m." On 12/08/23 at approximately 3:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.	F 840		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, Resident and staff interviews, and facility documentation review, the	F 919		

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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 919	Continued From page 49 facility staff failed to maintain a Resident call system for Residents to call for staff assistance, on three of four nursing units. The findings included: On three of four nursing units, the facility staff failed to ensure that there was a Resident call system in the bathrooms and showers to allow Residents to call for staff assistance, if needed. On 12/5/23, during an initial tour of the facility it was noted that on three of the Resident care units, there was not a functional call bell system. The Residents were noted to have hand bells and/or tap bells at the bedside. There was no device noted in the Resident bathrooms, many of which also contained showers. During Resident interviews conducted 12/5/23-12/6/23, Resident #54 reported that the toileted and showered in his room's bathroom independently without any supervision or assistance from staff. When asked how he would call for assistance if he needed help, Resident #54 said, "I have no way to call other than yell, the system has been broken for months because of lightening". Resident #77 reported that she toileted without staff assistance. When asked, if she needed help how she would notify the facility staff? The Resident said, "I try to leave the door cracked so if I call out, they can hear me". On 12/6/23 at 10:20 AM, an interview was conducted with LPN #6. LPN #6 confirmed that Resident #54 is "very independent" and does toilet and shower without any staff assistance.	F 919	F 919 1. Facility failed to have manual call bells in each resident's bathroom in 3 out of 4 units, facility immediately placed manual call bells in all affected bathrooms. 100% of residents had the potential to be affected. 100% of bathrooms audited to ensure that manual call bells placed in bathrooms without functioning call lights by Nursing home administrator or designee for units 100 and 200. 2. 100% of all staff educated on maintaining manual call bells in all bathrooms and resident rooms when facility operating on emergency call bell system. 3. Nursing home effectively replaced all manual call bells with fully functioning electrical system on all units on 1/5/24. Maintenance Director to do weekly audit for 12 weeks on 15 randomly selected rooms and/or bathrooms to ensure proper functioning of new system. 4. Compliance Date 1/19/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 919	Continued From page 50 LPN #6 also confirmed that Resident #77 can toilet herself without staff assistance. On 9/28/23, an inspection was conducted at this facility and at that time the facility reported their call bell system would be functioning withing 8 weeks. During that inspection, the facility provided a document from the VSC Fire & Security Company dated 09/28/23. The read in part: After hours of troubleshooting, we have discovered in multiple places the existing wiring is "burned" and multiple location with inoperative stations. It is recommended to replace the entire system with a new nurse call system. After contacting (name of company) there is enough materials to get started and can support with on time delivers as this system replacement progresses. The plan is to replace all the existing system including wire and will work on and complete one (1) 20 room/unit pod at a time. The intention is to complete each unit/pod within a two (2) week period or within 8 weeks for the entire facility. On the afternoon of 12/7/23, an interview was conducted with the facility Administrator. The Administrator reported that the facility had a lightning strike in July 2023, that had disabled their call bell system for the entire facility. They had contracted with an outside company who was in the process of having to re-wire and install a new system. They had completed the installation of the call bell system on one unit, and it was noted to be operational. The administrator reported that due to the facility having a COVID outbreak the contractors didn't work for two weeks in November, which delayed the installation as well as the fact that they prioritized the fire monitoring system before the call bell	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 919	Continued From page 51 system. Review of the facility policy titled, "Resident Communication System and Call Light Policy" was conducted. The policy read, "It is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room and toilet/bath areas...". During the interview with the facility Administrator on 12/7/23, the above concerns were shared that the Residents on three nursing units did not have any means to call for assistance in the bathroom and shower if needed. The Administrator confirmed these observations. The administrator shared that each shift the nurses check to ensure that a call bell is in place at the bedside and every hour a staff member is to walk to hallway to identify if any hand bells and/or tap bells are heard. The Administrator further confirmed that this walk through doesn't include physically entering a Resident's room. On the morning of 12/8/23, the facility Administrator stated that in response to the concerns shared the day prior, they had procured enough tap bells and hand bells to place one in every bathroom as well. No further information was provided.	F 919		