STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3500 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/24/2023 through 10/26/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Six complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/24/23 through 10/26/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey. VA00057103-Substantiated without deficiency, VA00057503-Substantiated with deficiency, VA00000059915-Substantiated without deficiency, VA00058508-Substantiated with deficiency, VA00059508-Substantiated without deficiency and VA00059529-Substantiated with deficiency The census in this 177 certified bed facility was 133 at the time of the survey. The survey sample consisted of 35 resident reviews. An unannounced biennial State Licensure Inspection was conducted 10/24/23 through 10/26/23. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Six complaints were investigated during the survey. The census in this 177 licensed bed facility was 133 at the time of the survey. The survey sample consisted of 32 current resident reviews and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/7/23

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3400 PLANK ROAD FREDERICKSBURG, VA 22407

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F 000	Continued From page 1 seven closed record review. Corrections are required for compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.	F 000		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by. Based on a review of facility's documentation and staff interview, it was determined that the facility failed to convey personal funds in a timely manner for one of 39 residents in the sample, Resident #438. **The findings included:**	F 569	F569 1. Resident #438 received funds April 2023. 2. Residents that have discharged in the last 30 days audited to ensure funds distributed. 3. Administrator re-educated the BOM on patient fund account refund policy. 4. Audits will be conducted by ED/Designee to ensure funds were given timely to discharged residents weekly for 8 weeks. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance date: 11/21/2023	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 569	Continued From page 2 Resident #438 was admitted to the facility on 10/19/21 with diagnosis that included but were not limited to: chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), diabetes mellitus (DM), bipolar and candidiasis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/12/22, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, transfer, walking, locomotion, dressing, eating, hygiene and bathing. A review of the comprehensive care plan dated 10/20/21, which revealed, "FOCUS: Long term care in a SNF (skilled nursing facility) is required due to my self-care and safety awareness deficits. INTERVENTIONS: Observe behavior changes/mental status changes/mood state changes. Provide emotional support to resident/family as needed. Refer for psych intervention services as needed." A review of Resident #438's medical record revealed the resident was transferred to the hospital on 11/10/22, where she expired. An interview was conducted on 10/24/23 at 1:35 PM with the RP (responsible party) of Resident #438. When asked if she had received the personal fund check, RP stated, they did not send us the personal fund check till mid-April 2023.	F 569		

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F 569	Continued From page 3 An interview was conducted on 10/25/24 at 12:25 PM with OSM (other staff member) #1, the business office manager. Asked the process to convey personal funds once a resident is discharged from the facility, OSM #1 stated, the process to return personal funds is to close the account and wait about a week to see if there are any additional charges. Once that is done, we cut a check and then wait for the appropriate people to sign the check before it is mailed. This usually takes about 30-45 days. Asked if the period from 11/10/22 to April 2023 was meeting the standard, OSM #1 stated, no, this was an extended period of time for return of personal funds. I will need to see if there are notes in the folder of the reason for the delay. On 10/25/24 at 5:08 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the Regional Vice President of Operations and ASM #6, the Regional Director of Clinical Services were made aware of the finding. A review of the facility's "PFA (Patient Fund Account) Refund" policy which revealed, "Upon the death or discharge of a resident with personal funds on deposit with the facility that are less than the Medicaid Resource Level of $2,000.00 for a Medicaid resident, the Business Office must deliver all remaining monies to the appropriate person by processing a refund within thirty (30) days. (Federal Regulation 483.10)." No further information was provided prior to exit.	F 569		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 584	Continued From page 4 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F 584	F584 1. Resident #125 base of toilet was immediately cleaned. 2. An audit was conducted of resident rooms to ensure they maintained a clean, comfortable, homelike environment. 3. Administrator/Designee re-educated housekeeping department on ensuring residents rooms are maintained in a clean, comfortable, homelike environment and in good repair. 4. Room round audits will be conducted by Department Managers 5 times a week to ensure Residents rooms are maintained in a clean, comfortable, homelike environment. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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FREDERICKSBURG HEALTH AND REHAB	3990 PLANK ROAD FREDERICKSBURG, VA 22407

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F 584	Continued From page 5 sound levels. This REQUIREMENT is not met as evidenced by. Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to maintain a clean, comfortable and homelike environment for one of 39 residents in the survey sample; Resident #125. The findings include: On 10/24/23 at 10:32 AM, an observation was made of Resident #125's room. The base of the toilet around the area where the bolts hold the toilet to the floor had dark brown / black substance all over it. On 10/24/23 at 3:33 PM and 10/25/23 at 10:02 AM, there was no change to the above observation. On 10/26/23 at 9:34 AM, there was no change to the above observation. At this time, OSM #17 (Other Staff Member), a housekeeper, was asked about the substance on the toilet base. He said he would clean it now. He sprayed a cleaner on it and the substance immediately dispersed, indicating it was something that could easily be cleaned and was not a permanent stain. He stated it should have been cleaned before now. A policy was requested for clean/comfortable/homelike environment / housekeeping services. None was provided On 10/26/23 at 10:30 AM, ASM #1 (Administrative Staff Member), the Administrator, was made aware of the findings. No further information was provided by the end of the	F 584		

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F 584	Continued From page 6 survey.	F 584		
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, clinical record review and facility document review, it was determined the facility staff failed to provide an accurate MDS (minimum data set) assessment for one out of 39 residents in the survey sample, Residents #135. The findings include: The facility staff failed to complete an accurate MDS (minimum data set), a discharge assessment for Resident #135. Resident #135 was sampled during the closed record review for transfer to hospital. Resident #135 was admitted to the facility on 4/16/23 with diagnosis that included but were not limited to: diabetes, congestive heart failure, hemiplegia and end stage renal disease. The most recent MDS (minimum data set) assessment, a discharge assessment, with an ARD (assessment reference date) of 8/2/23, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of Section A: Identification Information: A 2100. Discharge Status: 03. Acute Hospital.	F 641	F641 1. Resident #135 discharge MDS was immediately corrected to reflect discharged to home. 2. Audit of discharged residents MDS in the last 30 days to ensure appropriate coding. 3. Administrator/ Designee re-educated MDS department on properly coding per the RAI manual. 4. Audits will be conducted by MDS to ensure Discharged patients annual MDS was coded accurately weekly for 8 weeks. Results of audits will be reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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F 641	Continued From page 7	F 641		

A review of the comprehensive care plan dated 4/17/23 revealed, "FOCUS: The resident would like assistance in planning my next steps to be able to go home safely when my care/rehab goals are met. INTERVENTIONS: Appropriate referrals will be made to home health agencies and durable medical equipment companies prior to discharge. Help me get in touch with local contact agencies as needed. '

A review of the nursing progress note dated 8/2/23 at 6:31 PM revealed, "Resident Discharged home. Summary discharged and orders given to transporters per spouse request. Resident stable and no concerns voiced. Resident left facility via stretcher and accompanied by three transporters at 4:30 pm "

A review of the physician discharge summary dated 8/3/23 at 7:30 AM revealed, "DISCHARGED TO: x Home with family."

An interview was conducted on 10/26/23 at 9:45 AM with RN (registered nurse) #3, the MDS coordinator. Asked to review the 8/2/23 MDS Section A for Resident #135 and the progress note for 8/2/23. RN #3 stated, yes, he was discharged home, it was coded as discharged to hospital. He went to the hospital the week before and came back. I will correct this in MDS. Asked what standard is followed for completing the MDS, RN #3 stated, we follow the RAI (resident assessment instrument).

On 10/26/23 at 10:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the Regional Vice President of Operations and ASM #6, the

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F 641	Continued From page 8 Regional Director of Clinical Services were made aware of the finding. According to the RAI (resident assessment instrument) MDS Section A 2100 OBRA Discharge Assessment: "Steps for Assessment: Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Coding Instructions: Select the 2-digit code that corresponds to the resident's discharge status. Code 01, community (private home/apt., board/care, assisted living, group home) if discharge location is a private home, apartment, board and care, assisted living facility, or group home. Code 02, another nursing home or swing bed, if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds. Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons." No further information was provided prior to exit.	F 641		
F 656 SS=E	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	F 656		

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F 656	Continued From page 9 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s): (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656	F656 1. Resident #130 comprehensive care plan for trauma informed care has been developed. Resident #79 comprehensive care plan has been developed for contractures. Resident #6 hand splint care plan is being implemented. Resident #61 communication to dialysis center care plan is being implemented. 2. Current residents have the potential to be affected if their needs are not care planned and care plan is not followed. 3. DON/Designee re-educated Licensed staff on developing/implementing care plans.	

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F 656	Continued From page 10 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff /resident interviews and facility document review, it was determined the facility staff failed to develop/implement the care plan for four of 39 residents in the survey sample, Resident #130, Resident #6, Resident #79 and Resident #61. The findings include: 1. The facility staff failed to develop the comprehensive care plan for trauma informed care for Resident #130. Resident #130 was admitted to the facility on 8/29/23 with diagnosis that included but were not limited to: PTSD (post-traumatic stress disorder) and epilepsy. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 9/18/23, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating and limited assistance for bed mobility, transfer, walking and locomotion; extensive assistance for dressing and hygiene. MDS Section I: Active diagnosis: I 6100. Post Traumatic Stress Disorder coded as yes. A review of the comprehensive care plan dated 10/24/23, which revealed, "FOCUS: Resident has	F 656	4. Random audits will be conducted by DON/Designee of residents' care plans to ensure they were developed and are being implemented weekly for 8 weeks. Results of audits will be reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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F 656	Continued From page 11 an Alteration in Well-being related to PTSD. INTERVENTIONS: Assist resident with effective coping behaviors, try to maintain normal daily activities. Resident will be able verbalize feeling safe in her environment. Resident will openly discuss fear and triggers if able." A review of the physician's orders dated 9/6/23, revealed, "Monitor for target behaviors of spitting, combativeness, refusal of ADL (activities of daily living) care, refusal of showers, refusal of medications and document. Demonstrating Sexual inappropriate behavior towards staff. Report behavior changes to NP/MD if behaviors arise, every shift for monitoring Document what behavior is observed." An interview was conducted on 10/25/23 at 8:05 AM with Resident #130. Asked if the facility had developed a plan of care for PTSD/trauma. Resident #130 stated, no. An interview was conducted on 10/25/23 at 3:00 PM with LPN (licensed practical nurse) #5. Asked the purpose of the care plan, LPN #5 stated, it is to set out the goals and interventions specific to each resident for their care. When asked if a resident with a diagnosis of PTSD a care plan addressing trauma should have, LPN #5 stated, yes, there should be a care plan. An interview was conducted on 10/25/23 at 3:15 PM with RN #3, the MDS coordinator. Asked when the PTSD care plan for Resident #130 was developed, RN #3 stated, yesterday, the director of nursing asked me to run a list of residents with PTSD and her name was on it and she did not have a care plan, so one was initiated.	F 656		

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F 656	Continued From page 12 On 10/26/23 at 10:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the Regional Vice President of Operations and ASM #6, the Regional Director of Clinical Services were made aware of the finding. A review of the facility's "Care Plan Preparation" policy revealed, "A care plan directs the patient's nursing care from admission to discharge. The written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings and it embodies the components of the nursing process. Update and revise the plan throughout the patient's stay, based on the patient's response." No further information was provided prior to exit. 2. For Resident #79, the facility staff failed to develop a care plan for the resident's contractures (1). R79 was admitted to the facility on 8/3/23. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/9/23, the resident was coded as requiring the extensive physical assistance of two staff members for bed mobility, and as having impairment on both left and right sides of both her upper and lower extremities. On the following dates and times, R79 was observed lying in her bed, with contractions in both arms and both legs: 10/24/23 at 9:54 a.m., 1:00 p.m., and 2:30 p.m.; and 10/25/23 at 9:44 a.m. On 10/25 at 2:30 p.m. and 10/25/23 at 9:44 a.m., there was a folded thin blanket between the resident's knees. No other devices, wedges, cushions, or splints were observed on or near the	F 656		

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F 656	Continued From page 13 resident at any other observation. A review of R79's care plan dated 8/3/23 revealed no interventions to address the resident's contractures. On 10/25/23 at 1:21 p m , RN (registered nurse) #3, the MDS coordinator, was interviewed. She stated she or the other MDS staff members are responsible for developing the comprehensive care plan when a resident is admitted. She stated she relies on clinical record documentation and the MDS triggers to determine which care plans are needed. When asked if a resident's contractures should be included in the care plan, she stated: "Yes, I think so. Definitely." On 10/26/23 at 10:19 a m , ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6 the regional director of clinical services, were informed of these concerns. No further information was provided prior to exit REFERENCE (1) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretch (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm. 3. For Resident #6 (R6), the facility staff failed to implement the care plan for a hand splint.	F 656		

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F 656	Continued From page 14 On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/18/23, R6 was coded as having impairment of an upper extremity on one side of her body. On the following dates and times, R6 was observed lying in bed and not wearing a left hand splint: 10/24/23 at 9:29 a.m., 9:31 a.m., 1:19 p.m., and 2:33 p.m.; and 10/25/23 at 9:36 a.m. and 11:16 a.m. A review of R6's orders revealed the following order dated 7/28/21: "Apply hand and wrist splint daily to left hand in the morning related to CONTRACTURE, LEFT HAND." A review of R6's care plan dated 12/2/16 and updated 1/16/17 revealed, in part: "Left hand splint as ordered for comfort and positioning." On 10/25/23 at 11:21 a.m., LPN (licensed practical nurse) #9 accompanied the surveyor to R6's bedside. When asked if the resident was wearing a hand splint, LPN #9 stated: "No." When asked why the resident was not wearing a hand splint, he stated: "I don't know. I think it was on her before they did her morning care. They must have taken it off when they did care." When asked if R6 had an order for a hand splint, he stated: "I would have to check. I don't usually take care of her." When asked if the hand splint was anywhere in the room, LPN #9 opened all closets and drawers, and answered: "No. I don't see one anywhere." On 10/25/23 at 2:31 p.m., LPN #9 was interviewed again. He stated the purpose of a care plan is to make sure a resident's needs are	F 656		

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F 656	Continued From page 15 met. This includes all a resident's needs, and not just nursing needs. He stated the whole facility staff is responsible for implementing the care plan. On 10/25/23 at 5:05 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. No further information was provided prior to exit. 4. For Resident #61, the facility staff failed to follow the comprehensive care plan for written communication with the dialysis center. A review of the comprehensive care plan revealed one dated 9/3/23 for "I have alteration in Kidney Function Due to End Stage Renal Disease (ESRD), evidenced by hemodialysis." This care plan included an intervention dated 9/3/23 for "Written communication form with review of weights and any changes in condition between dialysis provider and living center." A review of the clinical record for Resident #61 revealed a physician's order dated 9/3/23 for dialysis services every Tuesday, Thursday, and Saturday. A review of the dialysis communication book revealed the following: One communication sheet that was completed but was not dated. There was no way to know what dialysis visit the data on the sheet pertained to. Three communication sheets were not completed by the facility but was completed by the dialysis center.	F 656		

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

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F 656	Continued From page 16 The facility did not provide pertinent data to the dialysis center. One of those sheets was also not dated. There was no way to know what dialysis visit the data from the dialysis center pertained to. All total, there were 22 opportunities for dialysis communication as of the survey review 10/25/23. There were 22 sheets in the book, including those with the noted missing information. On 10/26/23 at 9:58 AM, an interview was conducted with LPN #10 (Licensed Practical Nurse). When asked if the care plan documented to provide written communication with the dialysis center and the facility did not complete a communication form, was the care plan followed, she stated that it was not. When asked what was the purpose of the care plan, she stated it was so that the can follow the plan of care for the resident and helps them follow the orders to take care of the resident. On 10/26/23 at 10:30 AM, ASM #1 (Administrative Staff Member), the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	F 656	F657 1. Resident #79 care plan was reviewed and revised to reflect removal of foley catheter and compression stockings added. 2. Current residents' have the potential to be affected if their care plan is not reviewed and revised. 3. DON/Designee re-educated Licensed nurses on reviewing and revising comprehensive care plans. 4. Random audits of 10 residents will be conducted by DON/Designee to ensure comprehensive care plans were reviewed and revised for weekly for 8 weeks. Results of audits will be reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		

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F 657	Continued From page 17 resident (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the care plan for one of 39 residents in the survey sample. Resident #79. The findings include: For Resident #79 (R79), the facility staff failed to review and revise the resident's care plan to reflect the removal of a Foley catheter (1) and the addition of compression stockings. On the following dates and times, R79 was observed lying in her bed: 10/24/23 at 9:54 a.m., 1:00 p.m., and 2:30 p.m.; and 10/25/23 at 9:44 a.m. At each of these observations, R79 did not have a Foley catheter, and the resident was not wearing compression stockings on her legs.	F 657		

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F 657	Continued From page 18 A review of R79's clinical record revealed the following order dated 8/3/23: "Apply Compression Stockings one time a day." Further review of R79's clinical record revealed she was admitted to the facility with a Foley catheter, but the catheter was discontinued on 8/11/23. A review of R79's care plan dated 8/3/23 failed to reveal any information related to the compression stockings. This review revealed, in part: "I have a catheter...Catheter care daily and prn (as needed)...Change catheter as ordered by physician...Observe for pain near catheter and report to nursing...Observe urine output for dark color, presence of odor, blood, signs of infection and report to nursing...Position catheter below bladder, ensure tubing has no kinks, and secure for safety." On 10/25/23 at 1:21 p.m., RN (registered nurse) #3, the MDS (minimum data set) coordinator, was interviewed. When asked who is responsible for reviewing and revising care plans as residents' conditions and needs change, she stated: "The MDS staff review them quarterly and yearly, but the floor nurses and unit managers review them in between." She stated the floor nurses and unit managers have access to the care plans on the electronic medical record and should be updating them regularly. She stated R79's care plan should have been updated to remove the information about the Foley catheter, and to include the information about the compression stockings. **On 10/25/23 at 2:31 p.m., LPN (licensed practical nurse) #9 was interviewed. When asked who is**	F 657		

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F 657	Continued From page 19 responsible for updating the care plans, he stated: "If we see something that needs to be changed, the unit managers are responsible for updating the care plans." On 10/25/23 at 5:05 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. On 10/26/23 at 9:00 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. When asked who is responsible for updating care plans, she stated the MDS staff is responsible for this. She stated changes in resident conditions or status are discussed every morning in the morning meeting. She stated: "MDS takes it from there." On 10/26/23 at 2:16 p.m., ASM #1 stated the facility did not have a policy for reviewing and revising the care plan. REFERENCE (1) "A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder." This information is taken from the website https://medlineplus.gov/ency/article/003981.htm.	F 657	F658 1. Professional Standards of Practice during medication administration for resident #89 during administration are being followed. 2. Med pass audits of current residents on sodium bicarbonate conducted to ensure professional standards of practice are being followed. 3. DON/Designee re-educated Licensed nurses on professional standards of practice for administration of sodium bicarbonate. 4. DON/Designee will conduct random audits of med pass will be conducted weekly for 8 weeks to ensure professional standards of practice are followed for sodium bicarbonate. Results of audits will be reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	
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-	F 658		

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F 658	Continued From page 20 (i) Meet professional standards of quality This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to follow professional standards of practice for one of 39 residents in the survey sample, Resident #89. The findings include: For Resident #89 (R 89), the facility staff failed to administer the medication sodium bicarbonate per physician's order on multiple dates in October 2023. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/17/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 10/24/23 at approximately 9:30 a.m., an interview was conducted with R 89. The resident voiced concern about not getting sodium bicarbonate. A review of R 89's clinical record revealed a physician's order dated 10/7/23 for sodium bicarbonate 650 mg (milligrams) by mouth two times a day for heartburn and indigestion. A review of R 89's October 2023 MAR (medication administration record) revealed the same physician's order for sodium bicarbonate. On 10/20/23 at 5:00 p.m. and 10/23/23 at 5:00 p.m., the MAR documented the code, "7= Other/See Nurse Notes." A nurse's note dated 10/20/23 documented, "Pharmacy has been notified of need for this medication and will send tablets tonight." A nurse's note dated 10/23/23	F 658		

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F 658	Continued From page 21 documented, "NP (Nurse Practitioner) has been notified of missed dose of this medication." A review of the facility OTC (Over the Counter) stock medication list revealed the facility was responsible for purchasing and supplying sodium bicarbonate. On 10/25/23 at 12:52 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the supply coordinator is responsible for ordering sodium bicarbonate. LPN #3 stated that when there are ten pills left in an over-the-counter medication bottle, she writes a note on the 24-hour report indicating the medication needs to be ordered then the management team discusses this during the morning meeting and the supply coordinator orders more medication. LPN #3 further stated that there is also a supply list on another unit and nurses can request OTC medications from that list. On 10/25/23 at 2:10 p.m., an interview was conducted with OSM (other staff member) #3 (the supply coordinator). OSM #3 stated she has a form the nurses are supposed to fill out if an OTC medication is needed but if a medication is due and not available, the nurses should tell her, and she can go to the store and purchase the medication. On 10/25/23 at 5:05 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 22 § 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 follow a physician's order for one of 39 residents in the survey sample, Resident #79. The findings include: For Resident #79 (R79), the facility failed to apply compression stockings on the resident's legs as ordered by the physician. On the following dates and times, R79 was observed lying in her bed: 10/24/23 at 9:54 a.m., 1:00 p.m., and 2:30 p.m.; and 10/25/23 at 9:44 a.m. At each of these observations, the resident was not wearing compression stockings on her legs. A review of R79's clinical record revealed the following order dated 8/3/23: "Apply Compression Stockings one time a day." A review of R79's care plan dated 8/3/23 failed to reveal any information related to the compression stockings. On 10/25/23 at 2:18 p.m., CNA (certified nursing	F 684	F684 1. Compression stockings were applied to Resident #79. Care Plan was updated. 2. Audit of residents with Physician order for Ted Stocking. 3. DON/Designee re-educated Clinical staff on Following physician orders and updating Care Plans. 4. Random audits will be conducted by DON/Designee of resident care plans to ensure accuracy. Random audits will be conducted by DON/Designee to assure physician orders are being followed for Ted Stockings .Results of audits will be Reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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F 684	Continued From page 23 assistant) #14 was interviewed. She stated if a resident has an order for compression stockings, the order appears on the resident's electronic medical record the CNA is able to see. She stated the CNAs are usually responsible for applying compression stockings. She stated she cares frequently for R79, but did not realize the resident needed compression stockings. On 10/25/23 at 4:34 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated if a resident needs compression stockings, the doctor or nurse practitioner will write an order for it. She stated nurses and CNAs together are responsible for making sure residents have compression stockings if ordered. On 10/25/23 at 5:05 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. On 10/26/23 at 2:18 p.m., ASM #1 stated the facility did not have a policy for the application of compression stockings. No further information was provided prior to exit.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		

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F 688	Continued From page 24 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to implement interventions to prevent a decline in mobility for two of 39 residents in the survey sample. Residents #79 and #6 The findings include. 1. For Resident #79 (R79), the facility staff failed to implement interventions to prevent further loss of mobility related to her contractures (1). R79 was admitted to the facility on 8/3/23. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/9/23, the resident was coded as requiring the extensive physical assistance of two staff members for bed mobility, and as having impairment on both left and right sides of both her upper and lower extremities. On the following dates and times, R79 was observed lying in her bed, with contractions in both arms and both legs: 10/24/23 at 9:54 a.m., 1:00 p.m., and 2:30 p.m.; and 10/25/23 at 9:44	F 688	1. Splint was placed on Resident #6 per order. Resident #79 was re-assessed for contractures and picked up on Therapy Case Load prior to D/C to the hospital 2. Audit of Therapy Admission assessments of residents admitted to the facility with contractures. Audit of physician orders to ensure residents with splint is being followed. 3. DON/Designee educated Nursing staff on following physician orders. Director of Therapy In-Serviced therapy staff on Admission Assessment accuracy.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 25 a.m. On 10/25 at 2:30 p.m. and 10/25/23 at 9:44 a.m., there was a folded thin blanket between the resident's knees. No other devices, wedges, cushions, or splints were observed on or near the resident at any other observation. A review of R79's clinical record revealed no evidence of an assessment of her contractures or of any interventions to prevent further decline in her mobility due to the contractures. A review of the physical therapy screening dated 8/4/23 revealed either an "n" or "n/a (not applicable) in all areas of the assessment, including, "Does the potential exist for this patient to decline further without intervention?" This review revealed, in part: "Pt (patient) at baseline. No significant decline in functional status. Is total assist with bed mobility, ADL (activities of daily living). A review of an undated occupational therapy screening revealed "no significant change" in all areas of the assessment, including, "Does the potential exist for this patient to decline further without intervention?" This review revealed, in part: "Pt at baseline of functional status. Nursing reported pt family has requested to take resident home for nights. Therapy for w/c (wheelchair) fitting to increase positioning." A review of the clinical record revealed no additional therapy evaluations of R79's contractures. A review of physician/extender progress notes revealed the following note dated 8/16/2023 NURSE PRACTITIONER PROGRESS NOTE...8/16/2023...12 systems reviewed...	F 688	4. DON/Designee will conduct random audits of residents with splint orders weekly for 8 weeks. Administrator/Designee will review Admission Audits of residents with contractures weekly for 8 weeks. Results of audits will be Reviewed at the monthly QAPI meeting. Any noted trends will be Corrected. 5. Compliance Date 11/21/23	

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Musculoskeletal-denies joint pain, swelling, stiffness, paresthesia...
PHYSICAL EXAM...MUSCULOSKELETAL: Generalized weakness; no active joint swelling." This note was written by ASM (administrative staff member) #3, a nurse practitioner.

A review of R79's care plan dated 8/3/23 revealed no interventions to address the resident's contractures.

On 10/25/23 at 4:34 p.m., LPN (licensed practical nurse) #4 was interviewed. When asked if a resident with multiple contractures should be assessed for interventions to prevent further loss of mobility, he stated: "The doctor or nurse practitioner usually does this. They will write an order for a splint or something. Sometimes therapy will do it." He stated he was not aware of any devices or interventions currently ordered for R79's contractures.

On 10/26/23 at 8:22 a.m., OSM (other staff member), a physical therapist, was interviewed. When asked what is involved in an initial screening of a resident, he stated: "It is not an evaluation. Sometimes we look at the resident. We go off what the nurses tell us." When asked if he had observed R79's contractures when he performed her initial screening, he stated he could not remember specifically. He stated: "Nursing told me that she is bedbound with contractures." He stated he did not assess the resident's arm or leg contractures. He stated: "I did not do a full eval." He stated: "I think we may be picking her up for contractures this week." He added that no assessments or interventions to prevent further loss of mobility due to the resident's contractures had been put into place at

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F 688	Continued From page 27 the present time. On 10/26/23 at 9:00 a.m., LPN # 1, a unit manager, was interviewed. When asked what kinds of interventions should be put in place for a newly admitted resident who has contractures, she stated the facility protocol calls for a therapy screening for all new admissions. She stated: "Those departments would do a screening and let us know if a person requires any kind of device." If a resident has a contracture, but does not have a device to prevent further contracture or skin breakdown, therapy will do a full evaluation and recommend whatever is needed. She stated: "It's not okay for a resident to have contractures and for us not to do anything about them." On 10/26/23 at 9:16 a.m., LPN #10 was interviewed. She stated if a resident is admitted with contractures, the nurses should follow up with the doctor. She stated some residents already have positioning devices for the contractures, but if they do not have any devices or orders, the physician or nurse practitioner is responsible for ordering something. She added that sometimes the doctors rely on therapy to make recommendations, and that "every resident with a contracture should at least have something attempted for them." On 10/26/23 at 11:20 a.m., ASM (administrative staff member) #3, a nurse practitioner, and ASM #4, a nurse practitioner, were interviewed. When asked what they do when they perform a resident's physical assessment, ASM #4 stated: "We go in the room and look. We pull the covers back and look." When asked what her documentation revealed about what she saw regarding R79's contractures when she	F 688		

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F 688	Continued From page 28 completed a physical assessment on 8/16/23, ASM #3 did not answer. ASM #4 stated: "In my brain, this is 101 nursing. It is just routine." ASM #4 stated the nursing staff is responsible for initiating interventions to prevent a resident's loss of range of motion if a resident has contractures. ASM #3 was again asked what her documentation on 8/16/23 revealed about R79's contractures in both arms and both legs, she did not answer. ASM #4 interjected: "Specific items for contractures are given to us through therapy. We have no reason to think that this resident is not getting the basics. Unless someone alerts us, we don't have any way of knowing." ASM #4 was asked to show evidence that either the physician or the nurse practitioners had noticed or assessed R79 for the contractures, she stated she would need to look On 10/26/23 at 10:19 a.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. On 10/26/23 at 2:18 p.m., ASM #1 stated the facility did not have a policy for assessment/evaluation of residents with contractures. No further information was provided prior to exit. REFERENCE (1) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretch (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken	F 688		

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from the website https://medlineplus.gov/ency/article/003185.htm.

2. For Resident #6 (R6), the facility staff failed to apply a hand splint as ordered.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/18/23, R6 was coded as having impairment of an upper extremity on one side of her body.

On the following dates and times, R6 was observed lying in bed and not wearing a left hand splint: 10/24/23 at 9:29 a.m., 9:31 a.m., 1:19 p.m., and 2:33 p.m.; and 10/25/23 at 9:36 a.m. and 11:16 a.m.

A review of R6's orders revealed the following order dated 7/28/21: "Apply hand and wrist splint daily to left hand in the morning related to CONTRACTURE, LEFT HAND."

A review of R6's care plan dated 12/2/15 and updated 1/16/17 revealed, in part: "Left hand splint as ordered for comfort and positioning."

On 10/25/23 at 11:21 a.m., LPN (licensed practical nurse) #9 accompanied the surveyor to R6's bedside. When asked if the resident was wearing a hand splint, LPN #9 stated: "No." When asked why the resident was not wearing a hand splint, he stated: "I don't know. I think it was on her before they did her morning care. They must have taken it off when they did care." When asked if R6 had an order for a hand splint, he stated: "I would have to check. I don't usually take care of her." When asked if the hand splint was anywhere in the room, LPN #9 opened all closets

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F 688	Continued From page 30 and drawers, and answered, "No. I don't see one anywhere." On 10/25/23 at 2:18 p.m., CNA (certified nursing assistant) #14 was interviewed. She stated if a resident has an order for a hand splint, the order appears on the resident's electronic medical record the CNA is able to see. She stated the nurses are responsible for applying the hand splints. On 10/25/23 at 4:34 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated if a resident needs a hand splint, the doctor or nurse practitioner will write an order for it. She stated nurses are responsible for applying the hand splints as ordered. On 10/25/23 at 5:05 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. On 10/26/23 at 2:18 p.m., ASM #1 stated the facility did not have a policy for the application of hand splints. No further information was provided prior to exit.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible, and	F 689		

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F 689	Continued From page 31 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide safe supervision for one of 39 residents in the sample, Resident #106. **The findings include:** For Resident #106 (R106), the facility staff failed to supervise him for safety when he independently walked into two commercial parking lots adjacent to the facility. R106 was admitted to the facility with a history of a traumatic brain injury. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/10/23, R106 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status. He was coded as exhibiting no behaviors during the look back period, including wandering. He was coded as requiring supervision, and the physical assistance of one staff member for locomotion off the unit. He was coded as having no psychological diagnoses. On 10/24/23 at 12:20 p.m., R106 was observed putting his name only (no time) on the sign out sheet at the receptionist's desk, and independently walking out the front door of the facility. He spoke to a visitor in the facility parking lot. He walked east through the facility parking lot, through a grassy area between the facility and an adjacent commercial lot, and into the commercial	F 689	F689 1. Resident #106 was put on 1 on 1 Supervision. 2. Residents with Trauma were assessed for Safety. 3. DON provided training "Individual Care for Residents with Trauma" In-Service. 4. Administrator/Designee will conduct random audits weekly for 8 weeks of new admissions to assure facility is providing Safety measures for residents with trauma. Results will be reviewed monthly at QAPI Meeting. Any noted trends will be corrected 5. Compliance Date 11/21/23	

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parking lot. The parking lot contained parking spaces for at least three stores, and a Dunkin Donuts with a drive through. As R106 walked through the parking lot, he approached and spoke to two individuals who were walking back and forth to their vehicles, and seven vehicle drivers as they sat in the parking lot. Two cars had to quickly put on their brakes as he walked in front of them. He walked to the drive through area of the Dunkin Donuts business, and wove through parked/moving cars, approaching and speaking to the drivers of three cars in the drive through. He returned to the facility at 12:42 p.m.

On 10/25/23 at 8:05 a.m., R106 was observed leaving the facility through the front door. He walked west through the facility parking lot crossed a grassy area between the facility parking lot and an adjacent commercial parking lot, and entered the commercial parking lot. The resident disappeared from observation behind a building in this parking lot.

On 10/25/23 at 3:35 p.m., R106 was observed leaving the facility through the front door. He walked west through the facility parking lot and sat on a crate in the grassy area between the facility parking lot and the adjacent commercial parking lot. ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services joined in the observation. At the end of this observation, R106 was observed leaving the crate and walking into the adjacent commercial parking lot, disappearing behind a building. LPN (licensed practical nurse) #3 was asked to follow the resident by the management staff.

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A review of R106's clinical record revealed no details regarding the resident's traumatic brain injury. A review of the resident's hospital discharge note on the date of his facility admission, 5/26/22, revealed the traumatic brain injury was greater than 10 years old.

A review of a facility Psychiatric evaluation dated 7/25/22 revealed, in part: "Chief Complaint/Nature of Presenting Problem: refusal of care, irritability...He...has a history of TBI (traumatic brain injury. He is alert and oriented, he denied any psychiatric history. This is a consultation upon the request of staff who reported that patient has been refusing to take showers, and have his bed sheets changed. Upon interview today, patient with periodically irritable (sic) and stated 'I have the right to refuse showers. There are so many rules here' ..Reinforced facility rules, patient verbalized understanding... Recommendations: Continue to reinforce importance of personal hygiene and facility rules. No psychotropic medications are warranted at this time. Monitor for changes in mood or behaviors and notify/page [name of physician practice] as needed. Will continue to follow and provide consultation." Further review of the clinical record revealed no evidence of psychiatric monitoring or follow up.

A review of R106's Log of Patient Outings on 12/24/23 at 1:00 p.m. at the receptionist's desk revealed three entries on 10/23/23 beginning at 4:58 p.m. The resident's name was written in a different handwriting than the times of entry and exit. The log contained an additional five entries with no date, and with only one entry containing an exit time. All other date and time slots were

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blank. OSM (other staff member) #5, the receptionist, stated: "[R106] does not like to write down the times." She stated the resident signs his own names, and she writes the times in and out when she is sitting at the desk. She added: "I don't know what other receptionists do."

A review of R106's orders revealed the following order dated 5/26/22: "May go on pass and or LOA with responsible party with medications."

Further review of R106's clinical record revealed no additional information regarding assessments of R106's safety to leave the building and to walk through adjacent commercial parking lots.

A review of R106's care plan revealed no information related to R106's leaving the facility.

On 10/25 23 at 1:33 p.m., OSM #2, the director of social services, was interviewed. When asked to describe R106 from a psychosocial perspective, she stated the resident is "hyper," with short term memory deficits. She stated: "He has the mind of a child pretty much, like a little kid. You tell them not to touch the hot stove, and they won't touch it right then. The next thing you know, they have forgotten what you said, and they touch the hot stove." She added: "You have to try your best to protect them." She stated R106 understands in the moment, but is not going to retain instructions or requests. She stated R106's son felt his dad was a danger to himself living alone because R106 would walk out of the house, approach strangers in their cars, and would sometimes get in the cars with strangers. When asked if the resident is defiant, she stated he is not; he just cannot remember. When asked if the resident leaves the building independently, she said he

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does. When asked what he does when he leaves the building, she stated she is not sure. He is required to sign out when he goes out. She has seen him sitting on the crate in the grassy area to the left of the building. She stated she sees him "every so often" coming back into the building from "across the way." When asked about the resident's safety awareness, she stated it is not good, and does not waver. She stated, "A lot of times when he goes out, when we can, we try to monitor him and keep an eye on him to the best of our ability." When asked where those efforts are documented, she stated there was no documentation of this monitoring. When asked how the resident is safer at the facility than at home, given the fact that he is allowed to leave the facility unsupervised and wander through commercial parking lots, approaching strangers She stated: "That's a very good question. I had not thought about that." She stated she was not aware of any current safety assessments or psychological evaluations for R106.

On 10/25/23 at 2:18 p.m., CNA (certified nursing assistant) #14 was interviewed. She stated she works day shift and often is responsible for caring for R106. She estimated the resident leaves the facility 8 or 9 times a shift. She stated she does not know what he does when he leaves, but that she has seen him walking through the Dunkin Donuts parking lot. She stated he tells her he is going out to get fresh air.

On 10/25/23 at 2:31 p.m., LPN (licensed practical nurse) #9 was interviewed. When asked to describe R106, he stated: "He's a lot." He estimated the resident leaves the facility at least five times during every day shift. When asked where the resident goes when he leaves the

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F 689	Continued From page 36	F 689		

building, he stated: "I'm not sure. I think he just walks around. I've seen him walking from the far parking lot toward the building." When asked if the resident is safe to leave the building unsupervised, he stated: "I really don't know. He has been doing it ever since I started work here."

On 10/25/23 at 2:54 p.m., ASM #2 was interviewed. When asked to describe R106 from a psychosocial perspective, she stated: "He has the same affect all the time. He does say hi to me. He can make his needs known." When asked if R106 has memory problems, she stated: "I don't see any evidence of it." When asked if the resident has been assessed for higher level thinking, judgment, and safety to leave the building alone, she stated he has not, that she knows of. When asked where the resident goes when he leaves the building, she stated: "He goes off the property, right where the trees are, on the [west] side." When asked if the resident wanders through the adjacent commercial parking lots, she stated: "I can't tell you if he goes in the parking lots. He just walks back and forth." When asked if the facility had ever received complaints about the resident's walking in the adjacent parking lots, she stated she thought one of the adjacent businesses had complained, and the administrator at that time took care of it. When asked who is responsible for the resident's overall safety, she stated: "Technically, we are. But he is allowed to sign in and out, and go on LOA (leave of absence)."

On 10/25/23 at 3:45 p.m., after the management staff had observed the resident leaving the facility property and walking west into the parking lot, ASM #1, the administrator stated it is the resident's right to walk around the facility parking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 689	Continued From page 37 lot. She added: "He is a 12 BIMS. I didn't know he was walking to other parking lots." On 10/26/23 at 11:20 a.m., ASM #3, a nurse practitioner, and ASM #4, a nurse practitioner, were interviewed. When asked if they had been aware that R106 was leaving the building and walking into the adjacent commercial parking lots, approaching strangers both inside and outside of cars, ASM #4 stated: "We were not. We were not updated about these behaviors until yesterday." She added that when people have traumatic brain injuries, sometimes they are different. She stated: "This change [in R106's behavior] is something acute." On 10/25/23 at 5:05 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. On 10/26/23 at 2:18 p.m., ASM #1 stated the facility did not have a policy for supervision of residents for safety. No further information was provided prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3509 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 38 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide respiratory services in a sanitary manner for one of 39 residents in the survey sample, Resident #138. The findings include: For Resident #138 (R 138), the facility staff failed to maintain and store nebulizer equipment in a sanitary manner. On the following dates and times, R 138 was observed in his room, 10/24/23 at 9:25 a.m. and 2:35 p.m.; and 10/25/23 at 9:40 a.m. At each observation, a nebulizer machine was positioned on the overbed table. The nebulizer tubing was dated 10/15/23, and the nebulizer mask was uncovered, and resting on top of a plastic bag on the overbed table. A review of R 138's orders revealed the following order dated 10/4/23: "Budesonide Suspension 0.5 MG/2 ML (milligrams per milliliter) 1 vial inhale orally via nebulizer two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION." A review of R 138's October 2023 MAR (medication administration record) revealed he had received the medication as ordered. On 10/26/23 at 9:00 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She	F 695	F695 1. Resident #138 is receiving respiratory services in a sanitary manner. 2. Audit of current residents with nebulizer equipment to ensure it is maintained and stored in a sanitary manner. 3. DON/Designee re-educated Licensed staff on storing and maintaining nebulizer equipment in a sanitary manner. 4. Random audits of residents with nebulizer equipment will be conducted by DON/Designee weekly for 8 weeks to ensure it is maintained and stored in a sanitary manner. Results of audits will be reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 695	Continued From page 39 stated nebulizer tubing should be changed weekly, at a minimum, and more often if it gets dirty. She stated the date on the tubing should be the date the tubing was most recently changed. She stated the mask should be cleaned after each use, and stored in a plastic bag for infections control purposes On 10/26/23 at 9:16 a.m., LPN #10 was interviewed. She stated nebulizer tubing should be changed every seven days, and the date on the tubing indicates the date it was last changed. She stated the nebulizer mask should be stored in a clean plastic bag between uses to prevent the spread of infection. On 10/26/23 at 10:19 a.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns On 10/26/23 at 2:18 p.m., ASM #1 stated the facility did not have a policy for storage of nebulizer equipment No further information was provided prior to exit. REFERENCE (1) "Budgeoned (Pentecost EC) is used to treat Crohn's disease (a condition in which the body attacks the lining of the digestive tract, causing pain, diarrhea, weight loss, and fever). Budesonide (Tarpeyo) is used to decrease protein in the urine in patients with primary immunoglobulin A nephropathy (kidney disease that occurs in some people when too much	F 695		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 695	Continued From page 40 immunoglobin A builds up in the kidney, causing inflammation). Budesonide is in a class of medications called corticosteroids. It works by decreasing inflammation (swelling) in the digestive tract of people who have Crohn's disease or in the kidney of people with nephropathy." This information is taken from the website https://medlineplus.gov/druginfo/meds/a608007.html.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence communication with the dialysis center for each dialysis visit for one of 39 residents in the survey sample, Resident #61. The findings include: A review of the clinical record for Resident #61 revealed a physician's order dated 9/3/23 for dialysis services every Tuesday, Thursday, and Saturday. A review of the dialysis communication book revealed the following: One communication sheet that was completed but was not dated.	F 698	F698 1. Resident #61 has evidence of ongoing communication with the dialysis center. 2. Current residents that receive dialysis were audited to ensure evidence of ongoing communication with the dialysis center. 3. DON/Designee re-educated Licensed nurses on dialysis policy.	

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FREDERICKSBURG HEALTH AND REHAB	3908 PLANK ROAD FREDERICKSBURG, VA 22407

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F 698	Continued From page 41 There was no way to know what dialysis visit the data on the sheet pertained to. Three communication sheets were not completed by the facility but was completed by the dialysis center. The facility did not provide pertinent data to the dialysis center. One of those sheets was also not dated. There was no way to know what dialysis visit the data from the dialysis center pertained to. All total, there were 22 opportunities for dialysis communication as of the survey review 10/25/23. There were 22 sheets in the book, including those with the noted missing information. A review of the comprehensive care plan revealed one dated 9/3/23 for "I have alteration in Kidney Function Due to End Stage Renal Disease (ESRD), evidenced by hemodialysis." This care plan included an intervention dated 9/3/23 for "Written communication form with review of weights and any changes in condition between dialysis provider and living center." On 10/26/23 at 9:58 AM, an interview was conducted with LPN #10 (Licensed Practical Nurse). She stated that the communication sheets are supposed to be filled in for every dialysis visit by the facility and the dialysis center and that the pages should be dated. She stated that the purpose for the communication book is for open communication with the dialysis center so the resident's dialysis provider and facility provider know what is going on with the resident related to dialysis. A review of the facility policy, "Coordination of Hemodialysis" documented, "...There will be communication between the facility and the ESRD (End Stage Renal Disease) facility regarding the resident....1. A communication	F 698	4. DON/Designee will audit dialysis residents to ensure evidence of ongoing communication with the dialysis center weekly for 8 weeks. Results of audits will be reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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FREDERICKSBURG HEALTH AND REHAB	3990 PLANK ROAD FREDERICKSBURG, VA 22407

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F 698	Continued From page 42 format will be initiated by the facility for any resident going to an ESRD facility for hemodialysis...2. Nursing will collect information regarding the resident to send to the ESRD facility with the resident- information recommended but not limited to: A. Resident information - face sheet, B. Copy of current physician orders, C. Copy of plan of care, D. Blank progress note, E. Blank ESRD communication form; 3. Nursing will send the resident information with the resident to the designated appointments at the ESRD facility. Nursing will give a brief summary of the physical, mental and emotional condition, oral intake, activity tolerance and change in physician orders since the last appointment. 4. The ESRD facility is to review and complete the ESRD communication form at each visit. 5. Upon the resident's return to the facility, nursing will review the ESRD communication form and communicate with the resident's physician and other ancillary departments as needed. 6. The facility will notify the ESRD facility of scheduled resident care conferences through the communication forms. 7. The completed ESDR form must be maintained as part of the medical record..." On 10/26/23 at 10:30 AM, ASM #1 (Administrative Staff Member), the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	F 698		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699		

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F 699	Continued From page 43 trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide trauma informed care for 1 of 39 residents in the sample Resident #130. The findings include: Resident #130 was admitted to the facility on 8/29/23 with diagnosis that included but were not limited to: PTSD (post-traumatic stress disorder) and epilepsy. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 9/18/23, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating and limited assistance for bed mobility, transfer, walking and locomotion; extensive assistance for dressing and hygiene. MDS Section I: Active diagnosis: I6100.Post Traumatic Stress Disorder coded as yes. A review of the comprehensive care plan dated 10/24/23, which revealed, "FOCUS: Resident has an Alteration in Well-being related to PTSD. INTERVENTIONS: Assist resident with effective	F 699	F699 1. Resident #130 is receiving trauma informed care. 2. Audit of current residents to ensure trauma informed care is being provided to qualified residents. 3. DON/Designee re-educated staff on trauma informed care. 4. DON/Designee will audit residents that qualified for trauma informed care to ensure it was provided weekly for 8 weeks. Results of audits will be reviewed at the monthly QAPI meeting. Any noted trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	1900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 699	Continued From page 44 coping behaviors, try to maintain normal daily activities. Resident will be able verbalize feeling safe in her environment. Resident will openly discuss fear and triggers if able." A review of the physician's orders dated 9/6/23, revealed, "Monitor for target behaviors of spitting, combativeness, refusal of ADL (activities of daily living) care, refusal of showers, refusal of medications and document. Demonstrating Sexual inappropriate behavior towards staff. Report behavior changes to NP/MD if behaviors arise. every shift for monitoring Document what behavior is observed." A review of the MAR-TAR (medication administration record-treatment administration record) for September 2023 and October 2023 revealed two shifts (day shift 9/9/23 and day shift 10/2/23) where "target behaviors of spitting, combativeness, refusal of ADL (activities of daily living) care, refusal of showers, refusal of medications and document. Demonstrating Sexual inappropriate behavior towards staff" were observed. A review of the nursing progress note dated 9/9/23 at 2:41 PM revealed, "X- Ray not able to be performed by mobile company today. X-Ray rescheduled for Monday. Patient continues to demonstrate sexually inappropriate behaviors towards other patients and staff. Pt. continues to be redirected." No progress notes for 10/2/23 episode. An interview was conducted on 10/25/23 at 8:05 AM with Resident #130. Asked if the facility were providing care for her related to PTSD/trauma, Resident #130 stated, not that I know of.	F 699		

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 699	Continued From page 45 An interview was conducted on 10/25/23 at 3:00 PM with LPN (licensed practical nurse) #5. Asked what specific care is provided to residents with trauma / PTSD. LPN #5 stated, we monitor for behaviors and let the nurse practitioner know if there are any. An interview was conducted on 10/25/23 at 3:15 PM with OSM (other staff member) #2, the social services director. Asked what services and care is being provided for Resident #130. OSM #2 stated, we are not providing her with anything. She was not on my list. An interview was conducted on 10/25/23 at 3:35 PM with RN (registered nurse) #1. Asked what trauma informed care is being provided to Resident #130. RN #1 stated, we observe her for behaviors, notify the nurse practitioner and refer to psychiatry. On 10/26/23 at 10:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the Regional Vice President of Operations and ASM #6, the Regional Director of Clinical Services were made aware of the finding. On 10/26/23 at 3:00 PM, ASM #1, the administrator, informed us there was no policy related to trauma informed care. No further information was provided prior to exit.	F 699		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services	F 710		

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F 710	Continued From page 46 A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable This REQUIREMENT is not met as evidenced by Based on observation, staff interview, and clinical record review, the facility staff failed to provide physician oversight of a resident's care for one of 39 residents in the survey sample. Resident #79 The findings include: For Resident #79 (R79), the facility staff failed provide physician (and/or nurse practitioner) supervision to assess a resident to prevent further loss of mobility related to her contractures (1) R79 was admitted to the facility on 8/3/23. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/9/23, the resident was coded as requiring the extensive physical assistance of two staff members for bed mobility, and as having impairment on both left and right sides of both her	F 710	F710 1. Resident #79 is receiving physician oversight for contractures. 2. An audit of residents with contractures conducted to ensure physician supervision to prevent further loss of mobility. 3. DON/Designee educated Medical Director on physician supervision requirements for resident care. 4. DON/Designee will audit residents with contractures to ensure physician supervision. Results of audits will be reviewed at the monthly QAPI meeting. Any trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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F 710	Continued From page 47 upper and lower extremities. On the following dates and times, R79 was observed lying in her bed, with contractions in both arms and both legs: 10/24/23 at 9:54 a.m., 1:00 p.m., and 2:30 p.m.; and 10/25/23 at 9:44 a.m. On 10/25 at 2:30 p.m. and 10/25/23 at 9:44 a.m., there was a folded thin blanket between the resident's knees. No other devices, wedges, cushions, or splints were observed on or near the resident at any other observation. A review of R79's clinical record revealed no evidence of an assessment of her contractures or of any interventions to prevent further decline in her mobility due to the contractures. A review of the physical therapy screening dated 8/4/23 revealed either an "n" or "n/a (not applicable) in all areas of the assessment, including, "Does the potential exist for this patient to decline further without intervention?" This review revealed, in part: "Pt (patient) at baseline No significant decline in functional status. Is total assist with bed mobility, ADL (activities of daily living). A review of an undated occupational therapy screening revealed "no significant change" in all areas of the assessment, including, "Does the potential exist for this patient to decline further without intervention?" This review revealed, in part: "Pt at baseline of functional status. Nursing reported pt family has requested to take resident home for nights. Therapy for w/c (wheelchair) fitting to increase positioning." A review of the clinical record revealed no therapy evaluations of R79's contractures.	F 710		

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F 710	Continued From page 48 A review of physician/extender progress notes revealed the following note dated 8/16/2023 NURSE PRACTITIONER PROGRESS NOTE...8/16/2023...12 systems reviewed... Musculoskeletal-denies joint pain, swelling, stiffness, paresthesia... PHYSICAL EXAM...MUSCULOSKELETAL: Generalized weakness, no active joint swelling." This note was written by ASM (administrative staff member) #3, a nurse practitioner. A review of R79's care plan dated 8/3/23 revealed no interventions to address the resident's contractures. On 10/25/23 at 4:34 p.m., LPN (licensed practical nurse) #4 was interviewed. When asked if a resident with multiple contractures should be assessed for interventions to prevent further loss of mobility, he stated: "The doctor or nurse practitioner usually does this. They will write an order for a splint or something. Sometimes therapy will do it." He stated he was not aware of any devices or interventions currently ordered for R79's contractures. On 10/26/23 at 8:22 a.m., OSM (other staff member), a physical therapist, was interviewed. When asked what is involved in an initial screening of a resident, he stated: "It is not an evaluation. Sometimes we look at the resident. We go off what the nurses tell us." When asked if he had observed R79's contractures when he performed her initial screening, he stated he could not remember specifically. He stated: "Nursing told me that she is bedbound with contractures." He stated he did not assess the resident's arm or leg contractures. He stated: "I	F 710		

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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did not do a full eval." He stated: "I think we may be picking her up for contractures this week." He added that no assessments or interventions to prevent further loss of mobility due to the resident's contractures had been put into place at the present time.

On 10/26/23 at 9:16 a.m., LPN #10 was interviewed. She stated if a resident is admitted with contractures, the nurses should follow up with the doctor. She stated some residents already have positioning devices for the contractures, but if they do not have any devices or orders, the physician or nurse practitioner is responsible for ordering something. She added that sometimes the doctors rely on therapy to make recommendations, and that "every resident with a contracture should at least have something attempted for them."

On 10/26/23 at 11:20 a.m., ASM (administrative staff member) #3, a nurse practitioner, and ASM #4, a nurse practitioner, were interviewed. When asked what they do when they perform a resident's physical assessment, ASM #4 stated: "We go in the room and look. We pull the covers back and look." When asked what her documentation revealed about what she saw regarding R79's contractures when she completed a physical assessment on 8/16/23, ASM #3 did not answer. ASM #4 stated: "In my brain, this is 101 nursing. It is just routine." ASM #4 stated the nursing staff is responsible for initiating interventions to prevent a resident's loss of range of motion if a resident has contractures. ASM #3 was again asked what her documentation on 8/16/23 revealed about R79's contractures in both arms and both legs, she did not answer. ASM #4 interjected: "Specific items

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F 710	Continued From page 50 for contractures are given to us through therapy. We have no reason to think that this resident is not getting the basics. Unless someone alerts us, we don't have any way of knowing." ASM #4 was asked to show evidence that either the physician or the nurse practitioners had noticed or assessed R79 for the contractures, she stated she would need to look. On 10/26/23 at 10:19 a.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. On 10/26/23 at 2:18 p.m., ASM #1 stated the facility did not have a policy for physician supervision or resident care. No further information was provided prior to exit. REFERENCE (1) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.	F 710		
F 741 SS=E	Sufficient/Competent Staff Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 741		

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F 741	Continued From page 51 practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide trauma informed care education for five of five staff reviewed. The findings include: During the course of an investigation of Resident #130's PTSD (post-traumatic stress disorder) / trauma informed care, five staff who were caring for Resident #130 were chosen to have their education files reviewed; RN (registered nurse) #1, LPN (licensed practical nurse) #5, LPN #11, CNA (certified nursing assistant) #5 and CNA	F 741	F741 1. Current staff have received Trauma Informed Care education. 2. Current staff have the potential to be affected. 3. ED/Designee provided re-education to HR on mandatory education for Staff. 4. ED/Designee will audit new hires records to ensure evidence of mandatory education of Trauma Informed Care weekly for 8 weeks. Results of audits will be reviewed at the monthly QAPI meeting. Any trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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F 741	Continued From page 52 #15. An interview was conducted on 10/25/23 at 3:00 PM with LPN #5. When asked if she had received any specific training for trauma informed care, LPN #5 stated, no, we have abuse training. An interview was conducted on 10/25/23 at 3:35 PM with RN #1. Asked what trauma informed care education he had received, RN #1 stated, my start date was just three to four weeks ago. There has been abuse education but no trauma informed care. I did have that education at my previous place. On 10/26/23 at 12:00 PM, ASM (administrative staff member) #2, the director of nursing stated, we do not have any education of staff on trauma informed care, nor any other information on PTSD this resident. We do provide abuse education and there is training related to trauma in the abuse training. On 10/26/23 at 1:40 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #5, the Regional Vice President of Operations and ASM #6, the Regional Director of Clinical Services were made aware of the finding. No further information was provided prior to exit.	F 741		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 745		

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F 745	Continued From page 53 by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide medically related social services for two of 39 residents in the survey sample, Residents #106 and #130. The findings include: 1. For Resident #106 (R106), the facility social worker failed to provide for psychological and safety assessments for this resident, who left the facility independently and walked through commercial parking lots adjacent to the facility. R106 was admitted to the facility with a history of a traumatic brain injury. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/10/23, R106 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status. He was coded as exhibiting no behaviors during the look back period, including wandering. He was coded as requiring supervision, and the physical assistance of one staff member for locomotion off the unit. He was coded as having no psychological diagnoses. On 10/24/23 at 12:20 p.m., R106 was observed putting his name only (no time) on the sign out sheet at the receptionist's desk, and independently walking out the front door of the facility. He spoke to a visitor in the facility parking lot. He walked east through the facility parking lot, through a grassy area between the facility and an adjacent commercial lot, and into the commercial parking lot. The parking lot contained parking	F 745	F745 1. Resident #106 and #130 are receiving medically related social services. 2. Current residents' audited to ensure they are receiving medically related social services if indicated. 3. ED/Designee re-educated social services of providing medically related social services. 4. ED/Designee will randomly audit 10 residents weekly for 8 weeks to ensure they are provided medically related social services if indicated. Results of audits will be reviewed at the monthly QAPI meeting. Any trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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spaces for at least three stores, and a Dunkin Donuts with a drive through. As R106 walked through the parking lot, he approached and spoke to two individuals who were walking back and forth to their vehicles, and seven vehicle drivers as they sat in the parking lot. Two cars had to quickly put on their brakes as he walked in front of them. He walked to the drive through area of the Dunkin Donuts business, and wove through parked/moving cars, approaching and speaking to the drivers of three cars in the drive through. He returned to the facility at 12:42 p.m.

On 10/25/23 at 8:05 a.m., R106 was observed leaving the facility through the front door. He walked west through the facility parking lot, crossed a grassy area between the facility parking lot and an adjacent commercial parking lot, and entered the commercial parking lot. The resident disappeared from observation behind a building in this parking lot.

On 10/25/23 at 3:35 p.m., R106 was observed leaving the facility through the front door. He walked west through the facility parking lot and sat on a crate in the grassy area between the facility parking lot and the adjacent commercial parking lot. ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services joined in the observation. At the end of this observation, R106 was observed leaving the crate and walking into the adjacent commercial parking lot, disappearing behind a building. LPN (licensed practical nurse) #3 was asked to follow the resident by the management staff.

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F 745	Continued From page 55 A review of R106's clinical record revealed no details regarding the resident's traumatic brain injury. A review of the resident's hospital discharge note on the date of his facility admission, 5/26/22, revealed the traumatic brain injury was greater than 10 years old. A review of a facility Psychiatric evaluation dated 7/25/22 revealed, in part: "Chief Complaint/Nature of Presenting Problem: refusal of care, irritability...He...has a history of TBI (traumatic brain injury. He is alert and oriented, he denied any psychiatric history. This is a consultation upon the request of staff who reported that patient has been refusing to take showers, and have his bed sheets changed. Upon interview today, patient with periodically irritable (sic) and stated 'I have the right to refuse showers. There are so many rules here'. Reinforced facility rules, patient verbalized understanding...Recommendations: Continue to reinforce importance of personal hygiene and facility rules. No psychotropic medications are warranted at this time. Monitor for changes in mood or behaviors and notify/page [name of physician practice] as needed. Will continue to follow and provide consultation." Further review of the clinical record revealed no evidence of psychiatric monitoring or follow up. A review of R106's Log of Patient Outings on 12/24/23 at 1:00 p.m. at the receptionist's desk revealed three entries on 10/23/23 beginning at 4:58 p.m. The resident's name was written in a different handwriting than the times of entry and exit. The log contained an additional five entries with no date, and with only one entry containing an exit time. All other date and time slots were blank. OSM (other staff member) #5, the	F 745		

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receptionist, stated: "[R106] does not like to write down the times." She stated the resident signs his own names, and she writes the times in and out when she is sitting at the desk. She added: "I don't know what other receptionists do."

A review of R106's orders revealed the following order dated 5/26/22: "May go on pass and or LOA with responsible party with medications."

Further review of R106's clinical record revealed no additional information regarding assessments of R106's safety to leave the building and to walk through adjacent commercial parking lots.

A review of R106's care plan revealed no information related to R106's leaving the facility.

On 10/25 23 at 1:33 p.m., OSM #2, the director of social services, was interviewed. When asked to describe R106 from a psychosocial perspective, she stated the resident is "hyper," with short term memory deficits. She stated: "He has the mind of a child pretty much, like a little kid. You tell them not to touch the hot stove, and they won't touch it right then. The next thing you know, they have forgotten what you said, and they touch the hot stove." She added: "You have to try your best to protect them." She stated R106 understands in the moment, but is not going to retain instructions or requests. She stated R106's son felt his dad was a danger to himself living alone because R106 would walk out of the house, approach strangers in their cars, and would sometimes get in the cars with strangers. When asked if the resident is defiant, she stated he is not; he just cannot remember. When asked if the resident leaves the building independently, she said he does. When asked what he does when he leaves

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F 745	Continued From page 57 the building, she stated she is not sure. He is required to sign out when he goes out. She has seen him sitting on the crate in the grassy area to the left of the building. She stated she sees him "every so often" coming back into the building from "across the way." When asked about the resident's safety awareness, she stated it is not good, and does not waver. She stated: "A lot of times when he goes out, when we can, we try to monitor him and keep an eye on him to the best of our ability." When asked where those efforts are documented, she stated there was no documentation of this monitoring. When asked how the resident is safer at the facility than at home, given the fact that he is allowed to leave the facility unsupervised and wander through commercial parking lots, approaching strangers. She stated: "That's a very good question. I had not thought about that." She stated she was not aware of any current safety assessments or psychological evaluations for R106. On 10/25/23 at 5:05 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. A review of the facility's job description for the social services director revealed, in part: "Provide/arrange for social work services as indicated by resident/family needs...meet with appropriate facility staff concerning resident issues...genuine caring for and interest in elderly and disabled people in a nursing facility...The ideal candidate will possess good communication and interpersonal skills to interact with the facility's residents and work with the staff	F 745		

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F 745	Continued From page 58 members to ensure the residents' needs are maintained on an individual basis." No further information was provided prior to exit. The findings include: 2. For Resident #130, the facility staff failed to provide psychosocial follow up following the resident being admitted with a diagnosis of PTSD (post-traumatic stress disorder). Resident #130 was admitted to the facility on 8/29/23 with diagnosis that included but were not limited to: PTSD (post-traumatic stress disorder) and epilepsy. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 9/18/23, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating and limited assistance for bed mobility, transfer, walking and locomotion; extensive assistance for dressing and hygiene. MDS Section I: Active diagnosis: I6100 Post Traumatic Stress Disorder coded as yes. A review of the comprehensive care plan dated 10/24/23, which revealed, "FOCUS: Resident has an Alteration in Well-being related to PTSD. INTERVENTIONS: Assist resident with effective coping behaviors, try to maintain normal daily activities. Resident will be able verbalize feeling	F 745		

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F 745	Continued From page 59 safe in her environment. Resident will openly discuss fear and triggers if able." A review of the physician's orders dated 9/6/23, revealed, "Monitor for target behaviors of spitting, combativeness, refusal of ADL (activities of daily living) care, refusal of showers, refusal of medications and document. Demonstrating Sexual inappropriate behavior towards staff. Report behavior changes to NP/MD if behaviors arise. every shift for monitoring Document what behavior is observed." A review of the MAR-TAR (medication administration record-treatment administration record) for September 2023 and October 2023 revealed two shifts (day shift 9/9/23 and day shift 10/2/23) where "target behaviors of spitting, combativeness, refusal of ADL (activities of daily living) care, refusal of showers, refusal of medications and document. Demonstrating Sexual inappropriate behavior towards staff" were observed. A review of the nursing progress note dated 9/9/23 at 2:41 PM revealed, "X- Ray not able to be performed by mobile company today. X-Ray rescheduled for Monday. Patient continues to demonstrate sexually inappropriate behaviors towards other patients and staff. Pt. continues to be redirected." No progress notes for 10/2/23 episode. Further review of Resident #130's clinical record revealed no evidence of a psychosocial follow up by the social worker. An interview was conducted on 10/25/23 at 8:05 AM with Resident #130. Asked if the facility were providing care for her related to PTSD/trauma,	F 745		

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F 745	Continued From page 60 Resident #130 stated, not that I know of. An interview was conducted on 10/25/23 at 3:00 PM with LPN (licensed practical nurse) #5. Asked what specific care is provided to residents with trauma / PTSD, LPN #5 stated, we monitor for behaviors and let the nurse practitioner know if there are any. When asked if she had received any specific training for trauma informed care, LPN #5 stated, no, we have abuse training. An interview was conducted on 10/25/23 at 3:15 PM with OSM (other staff member) #2, the social services director. Asked what services and care is being provided for Resident #130, OSM #2 stated, we are not providing her with anything. She was not on my list. An interview was conducted on 10/25/23 at 3:35 PM with RN (registered nurse) #1. Asked what trauma informed care is being provided to Resident #130, RN #1 stated, we observe her for behaviors, notify the nurse practitioner and refer to psychiatry. On 10/26/23 at 10:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the Regional Vice President of Operations and ASM #6, the Regional Director of Clinical Services were made aware of the finding. A review of the facility document, "Social Worker Job Description," revealed, in part: "Conduct and document a social services evaluation, including identification of resident problems/needs; Provide/arrange for social work services as indicated by resident/family needs; Keep the resident's family informed of resident problems, personal needs, transfers and changes of level	F 745		

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F 745	Continued From page 61 assignment; Assure all documentation complies with applicable regulations; Act in compliance with all corporate, state, federal and other regulatory standards; Provide social work consultation to residents, families and staff as requested; Comply with the Residents' Rights and Facility Policies and Procedures." No further information was provided prior to exit.	F 745		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store and serve food in a sanitary manner in one of one kitchen.	F 812	F812 1. The Dietary Staff is ensuring prepared food is accurately labeled and not stored in the original container, expired produce is discarded, dry good scoops and thickener is stored in a sanitary manner in the kitchen according to professional standards for food service safety. 2. Audit of kitchen to ensure prepared food is accurately labeled and not stored in the original container, expired produce is discarded, dry good scoops and thickener is stored in a sanitary manner in the kitchen according to professional standards for food service safety.	

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F 812	Continued From page 62 The findings include: The facility staff failed to accurately label prepared food not stored in the original container, discard expired produce, store dry good scoops and thickener in a sanitary manner in the facility kitchen. On 10/24/2023 at 8:30 a.m., an observation was conducted of the kitchen of the facility with OSM (other staff member) #4, dietary manager. Observation of the walk-in refrigerator revealed a four-shelf wire cart with a 5.2-quart plastic container with a white plastic lid on the third shelf labeled Ranch dressing with a prepared date of 5/10/23 and a use by date of 5/10/24. The container was observed to contain a brown pudding like substance. OSM #4 identified the substance as chocolate pudding and stated that it was not labeled or dated accurately. She stated that the container should be labeled with the accurate contents, date it was prepared and a use by date of 3 days later Further observation of the walk-in refrigerator revealed two cardboard boxes of fresh tomatoes stacked one on top of the other on the second shelf of a four-shelf wire cart. The bottom box of tomatoes was observed to contain tomatoes with visible white fuzzy substance on the surface of one tomato inside. The top box was observed to contain tomatoes with visible white fuzzy substance on the surface of three tomatoes inside the box, visible breakdown of the tomato skin with juice and seeds coming from the tomatoes and the base of the cardboard box was observed to be wet. OSM #4 observed the tomatoes and stated that the tomatoes were spoiled and needed to be discarded. She stated	F 812	3. The Dietary Manger/Designee re-educated staff on ensuring prepared food is accurately labeled and not stored in the original container, expired produce is discarded, dry good scoops and thickener is stored in a sanitary manner according to professional standards for food service safety. 4. The Dietary Manager/Designee will conduct weekly audits for 8 weeks to ensure prepared food is accurately labeled and not stored in the original container, expired produce is discarded, dry good scoops and thickener is stored in a sanitary manner in the kitchen according to professional standards for food service safety. Results of audits will be reviewed at the monthly QAPI meeting. Any trends will be corrected immediately. 5. Compliance Date: 11/21/2023	

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

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F 812	Continued From page 63 that they received produce every week and ordered them when they were on the menu, and these should have been discarded. Observation of the kitchen area revealed three large bins labeled "flour", "brown sugar" and "sugar." The bins were observed to contain scoops for the product located in scoop holders attached to the side of the bins. Observation of the scoop holders revealed multiple small black particles on the bottom surface of the holder. The scoops for the flour and the brown sugar were observed in the scoop holder resting on the black particles on the bottom of the holder. OSM #4 observed the black particle residue on the bottom surface of the holder and stated that the holders needed to be washed out and that it was probably coffee grounds in the holders. She stated that the scoop holders should be washed out regularly to keep residue from getting in there and touching the scoops Further observation of the kitchen area revealed a 25-pound box of instant food thickener that was approximately one half full located on the bottom shelf of a metal table. The plastic bag containing the thickener was observed to be open to air. - bag is open to air. OSM #4 stated that the thickener should not be open to air to keep it clean, and they were working on getting a storage bin to keep it in. She stated that the bag containing the thickener should be kept closed. The facility policy "Food Storage-Dry Goods" dated May 2014 documented in part, "Policy Statement: It is the center policy to insure [sic] all dry goods will be appropriately stored in accordance with guidelines of the USDA Food Code...The Food Services Director or designee	F 812		

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F 812	Continued From page 64 ensures that all packaged and canned food items shall be kept clean, dry, and properly sealed..." The facility policy "Food Storage: Cold" dated May 2014 documented in part, "... The Food Services Director/Cook(s) insures [sic] that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination..." The facility policy "Ice" dated May 2014 documented in part, "... The Food Services Director ensures that ice scoops are clean and stored in a separate container that limits exposure to dust and moisture retention..." The policy failed to provide guidance for scoops used for dry goods. On 10/25/2023 at 10:00 a.m., ASM (administrative staff member) #1, the interim administrator was made aware of the findings. No further information was provided prior to exit.	F 812		
F 825 SS=C	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or	F 825		

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F 825	Continued From page 65 §483.65(a)(2) in accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide therapy services to prevent further decline in mobility for one of 39 residents in the survey sample, Resident #79. The findings include: For Resident #79 (R79), the facility staff failed to obtain a therapy evaluation to prevent further loss of mobility related to her contractures (1). R79 was admitted to the facility on 8/3/23. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/9/23, the resident was coded as requiring the extensive physical assistance of two staff members for bed mobility, and as having impairment on both left and right sides of both her upper and lower extremities. On the following dates and times, R79 was observed lying in her bed, with contractions in both arms and both legs: 10/24/23 at 9:54 a.m., 1:00 p.m., and 2:30 p.m.; and 10/25/23 at 9:44 a.m. On 10/25 at 2:30 p.m. and 10/25/23 at 9:44 a.m., there was a folded thin blanket between the resident's knees. No other devices, wedges, cushions, or splints were observed on or near the	F 825	F 825 1. Resident #79 was re-assessed and picked up for Therapy services prior to D/Cing to the hospital. 2. Audit conducted of Admission Evaluations of residents admitted to facility with contractures. 3. Director of Therapy re-educated Therapy staff on accurate Admission Evaluation of residents with contractures. 4. Nursing Home Administrator or Designee will randomly audit new admissions with contractures to assure they are accurate weekly for 8 weeks. Results will be reviewed monthly at QAPI meeting. Any noted Trends will be corrected 5. Compliance Date 11/21/23	

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F 825	Continued From page 66 resident at any other observation. A review of R79's clinical record revealed no evidence of an assessment of her contractures or of any interventions to prevent further decline in her mobility due to the contractures. A review of the physical therapy screening dated 8/4/23 revealed either an "n" or "n/a (not applicable) in all areas of the assessment, including, "Does the potential exist for this patient to decline further without intervention?" This review revealed, in part: "Pt (patient) at baseline No significant decline in functional status. Is total assist with bed mobility, ADL (activities of daily living). A review of an undated occupational therapy screening revealed "no significant change" in all areas of the assessment, including, "Does the potential exist for this patient to decline further without intervention?" This review revealed, in part: "Pt at baseline of functional status. Nursing reported pt family has requested to take resident home for nights. Therapy for w/c (wheelchair) fitting to increase positioning." A review of the clinical record revealed no therapy evaluations of R79's contractures. On 10/25/23 at 4:34 p.m., LPN (licensed practical nurse) #4 was interviewed. When asked if a resident with multiple contractures should be assessed for interventions to prevent further loss of mobility, he stated: "The doctor or nurse practitioner usually does this. They will write an order for a splint or something. Sometimes therapy will do it." He stated he was not aware of any devices or interventions currently ordered for	F 825		

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F 825	Continued From page 67 R79's contractures. On 10/26/23 at 8:22 a.m., OSM (other staff member), a physical therapist, was interviewed. When asked what is involved in an initial screening of a resident, he stated: "It is not an evaluation. Sometimes we look at the resident. We go off what the nurses tell us." When asked if he had observed R79's contractures when he performed her initial screening, he stated he could not remember specifically. He stated: "Nursing told me that she is bedbound with contractures." He stated he did not assess the resident's arm or leg contractures. He stated: "I did not do a full eval." He stated: "I think we may be picking her up for contractures this week." He added that no assessments or interventions to prevent further loss of mobility due to the resident's contractures had been put into place at the present time. On 10/26/23 at 9:00 a.m., LPN # 1, a unit manager, was interviewed. When asked what kinds of interventions should be put in place for a newly admitted resident who has contractures, she stated the facility protocol calls for a therapy screening for all new admissions. She stated: "Those departments would do a screening and let us know if a person requires any kind of device." If a resident has a contracture, but does not have a device to prevent further contracture or skin breakdown, therapy will do a full evaluation and recommend whatever is needed. She stated: "It's not okay for a resident to have contractures and for us not to do anything about them." On 10/26/23 at 10:19 a.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #5, the regional	F 825		

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F 825	Continued From page 68 vice president of operations, and ASM #6, the regional director of clinical services, were informed of these concerns. On 10/26/23 at 2:18 p.m., ASM #1 stated the facility did not have a policy for therapy screenings and evaluations. No further information was provided prior to exit. REFERENCE (1) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.	F 825		