STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD GALAX, VA 24333

(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 11/13/23 through 11/16/23. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004		12/27/23

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

Electronically Signed

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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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Emergency Preparedness (EP) Plan was reviewed and updated annually. The findings included: The facility EP Plan was last reviewed and updated on 2/25/22. On 11/16/23 at 9:30 AM, a review of the facility EP Plan was conducted with the Administrator and Maintenance Director. The table of contents page of the facility EP Plan included the statement "Reviewed February 25, 2022." The Administrator verified the plan was last reviewed on 2/25/22 and stated typically the EP Plan was reviewed, updated, and brought through the QAPI (Quality Assurance and Performance Improvement) Committee during January or February of each year. The Administrator stated	E 004	1) The center reviewed and updated the Emergency Preparedness Plan (EPP) on 12/15/2023. 2) The center identified that the EPP had not been reviewed in 2023. The NHA/designee will ensure that the plan is reviewed annually in January of each calendar year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to update the EPP annually. 4) The NHA/designee will ensure the plan is reviewed by the QA committee in January of 2024 to ensure the plan is reviewed in January of each calendar year.	

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E 004	Continued From page 2 this had not been done in 2023 but was unable to provide a reason as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility EP Plan not being reviewed and updated annually. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 004		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan.	E 006		12/27/23

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E 006	Continued From page 3 The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.	E 006		

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E 006	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Emergency Preparedness (EP) Plan included a documented, facility-based, and community-based risk assessment utilizing an all-hazards approach that was reviewed and updated annually. The findings included: The facility's EP Plan was last reviewed and updated on 2/25/22 and the all-hazard risk assessment was last reviewed and updated on 9/16/22. On 11/16/23 at 9:30 AM, a review of the facility EP Plan was conducted with the Administrator and Maintenance Director. The table of contents page of the facility EP Plan included the statement "Reviewed February 25, 2022." The Administrator verified the plan was last reviewed on 2/25/22 and stated typically the EP Plan was reviewed, updated, and brought through the QAPI (Quality Assurance and Performance Improvement) Committee during January or February of each year. The facility Hazard and Vulnerability Analysis included in the facility EP Plan was dated 9/16/22 and read in part " ...Long Term Care communities are required to conduct and annually review their Hazard Vulnerability Analysis (HVA) ..." The administrator verified the all-hazard risk assessment was last reviewed on 9/16/22. The Administrator verified the all-hazard risk assessment and the EP Plan had not been	E 006	1) The center reviewed and updated the Emergency Preparedness Plan (EPP) on 12/15/2023, including the All-Hazard Risk Assessment. 2) The center identified that the All-Hazard Risk Assessment had not been reviewed in 2023. The NHA/designee will ensure that the plan is reviewed annually in January of each calendar year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to update the EPP annually, including the All-Hazard Risk Assessment. 4) The NHA/designee will ensure the plan is reviewed by the QA committee in January of 2024 to ensure the plan is reviewed in January of each calendar year.	

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E 006	Continued From page 5 reviewed and/or updated in 2023 but was unable to provide a reason as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility EP Plan not being reviewed and updated annually. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 006		
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,	E 013		12/27/23

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E 013	Continued From page 6	E 013		

and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

*Additional Requirements for PACE and ESRD Facilities:

*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.

*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.

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E 013	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Emergency Preparedness (EP) Policy and Procedures were reviewed and updated annually. The findings included: The facility's EP Policy and Procedures were last reviewed and updated on 2/25/22. On 11/16/23 at 9:30 AM, a review of the facility EP Plan was conducted with the Administrator and Maintenance Director. The table of contents page of the facility EP Plan included the statement "Reviewed February 25, 2022." The Administrator verified the plan including the policy and procedures were last reviewed on 2/25/22 and stated typically the EP Plan was reviewed, updated, and brought through the QAPI (Quality Assurance and Performance Improvement) Committee during January or February of each year. The Administrator was unable to provide a reason as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility's EP Policy and Procedures not being reviewed and updated annually. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 013	1) The center reviewed and updated the Emergency Preparedness Plan (EPP) on 12/15/2023, including Procedures. 2) The center identified that the EPP Procedures had not been reviewed in 2023. The NHA/designee will ensure that the plan is reviewed annually in January of each calendar year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to update the EPP annually, including Procedures. 4) The NHA/designee will ensure the plan is reviewed by the QA committee in January of 2024 to ensure the plan is reviewed in January of each calendar year.	
E 029 SS=D	Development of Communication Plan	E 029		12/27/23

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E 029	Continued From page 8 CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Emergency Preparedness (EP) Communication Plan was reviewed and updated annually. The findings included: The facility's EP Communication Plan was last reviewed and updated on 2/25/22. On 11/16/23 at 9:30 AM, a review of the facility EP Plan was conducted with the Administrator and Maintenance Director. The table of contents page of the facility EP Plan which included the Communication Plan included the statement "Reviewed February 25, 2022." The Administrator verified the plan was last reviewed on 2/25/22 and stated typically the entire EP Plan was reviewed, updated, and brought through the QAPI (Quality Assurance and Performance Improvement) Committee during January or February of each year.	E 029	1) The center reviewed and updated the Emergency Preparedness Plan (EPP) on 12/15/2023, including the Communication Plan. 2) The center identified that the EPP Communication Plan had not been reviewed in 2023. The NHA/designee will ensure that the plan is reviewed annually in January of each calendar year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to update the EPP annually, including the Communication Plan. 4) The NHA/designee will ensure the plan is reviewed by the QA committee in January of 2024 to ensure the plan is reviewed in January of each calendar year.	

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E 029	Continued From page 9 The Administrator verified the EP Communication Plan had not been reviewed and/or updated since 2/25/22 but was unable to provide a reason as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility EP Plan not being reviewed and updated annually. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 029		
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E 030		12/27/23

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E 030	Continued From page 10 (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following:	E 030		

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E 030	Continued From page 11 (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Emergency Preparedness (EP) Communication Plan including staff names and contact information was reviewed and updated annually. The findings included: The facility's staff names and contact information in the facility EP Plan was last reviewed and updated on 2/25/22. On 11/16/23 at 9:30 AM, a review of the facility	E 030	1) The center reviewed and updated the Emergency Preparedness Plan (EPP) on 12/15/2023, including Staff Names and Contact Information. 2) The center identified that the EPP had not been reviewed in 2023. The NHA/designee will ensure that the plan is reviewed annually in January of each calendar year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to update the EPP annually, including the Staff Names and Contact Information.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 030	Continued From page 12 EP Plan was conducted with the Administrator and Maintenance Director. The table of contents page of the facility EP Plan which included the Communication Plan included the statement "Reviewed February 25, 2022." The Communication Plan included the name and contact information for a Director of Nursing that was no longer employed by the facility. The Administrator verified the plan was last reviewed on 2/25/22 and stated typically the entire EP Plan was reviewed, updated, and brought through the QAPI (Quality Assurance and Performance Improvement) Committee during January or February of each year. The Administrator verified the EP Communication Plan had not been reviewed and/or updated since 2/25/22 but was unable to provide a reason as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility EP Plan not being reviewed and updated annually. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 030	4) The NHA/designee will ensure the plan is reviewed by the QA committee in January of 2024 to ensure the plan is reviewed in January of each calendar year. 5) Allegation of Compliance: 12/27/23	
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).	E 031		12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 11/16/2023

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GALAX HEALTH AND REHAB	836 GLENDALE RD GALAX, VA 24333

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E 031	Continued From page 13 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Emergency Preparedness (EP) Communication Plan including required contact information was reviewed and updated annually. The findings included:	E 031	1) The center reviewed and updated the Emergency Preparedness Plan (EPP) on 12/15/2023, including Required Contact Information. 2) The center identified that the EPP had not been reviewed in 2023. The NHA/designee will ensure that the plan is	

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E 031	Continued From page 14 The facility's EP Communication Plan contact information for the federal, state, regional, and local emergency preparedness staff, state licensing and certification agency, and the State Long Term Care Ombudsman had not been reviewed and updated since 2/25/22. On 11/16/23 at 9:30 AM, a review of the facility EP Plan was conducted with the Administrator and Maintenance Director. The table of contents page of the facility EP Plan which included the Communication Plan included the statement "Reviewed February 25, 2022." The Administrator verified the plan was last reviewed on 2/25/22 and stated typically the entire EP Plan was reviewed, updated, and brought through the QAPI (Quality Assurance and Performance Improvement) Committee during January or February of each year. The Administrator verified the EP Communication Plan including required contact information had not been reviewed and/or updated since 2/25/22 but was unable to provide a reason as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility EP Plan not being reviewed and updated annually. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 031	reviewed annually in January of each calendar year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to update the EPP annually, including Required Contact Information. 4) The NHA/designee will ensure the plan is reviewed by the QA committee in January of 2024 to ensure the plan is reviewed in January of each calendar year. 5) Allegation of Compliance: 12/27/23	
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d)	E 036		12/27/23

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E 036	Continued From page 15 §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036		

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E 036	Continued From page 16 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Emergency Preparedness (EP) Training and Testing Program was reviewed and updated annually. The findings included: The facility EP Training and Testing Program was last reviewed and updated on 2/25/22.	E 036	1) The center reviewed and updated the Emergency Preparedness Plan (EPP) on 12/15/2023, including the Training and Testing Program. 2) The center identified that the EPP had not been reviewed in 2023. The NHA/designee will ensure that the plan is reviewed annually in January of each calendar year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to update	

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E 036	Continued From page 17 On 11/16/23 at 9:30 AM, a review of the facility EP Plan was conducted with the Administrator and Maintenance Director. The table of contents page of the facility EP Plan including the Training and Testing Program included the statement "Reviewed February 25, 2022." The Administrator verified the plan was last reviewed on 2/25/22 and stated typically the EP Plan was reviewed, updated, and brought through the QAPI (Quality Assurance and Performance Improvement) Committee during January or February of each year. The Administrator stated this had not been done in 2023 but was unable to provide a reason as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility EP Plan including the Training and Testing Program not being reviewed and updated annually. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 036	the EPP annually, including the Training and Testing Program. 4) The NHA/designee will ensure the plan is reviewed by the QA committee in January of 2024 to ensure the plan is reviewed in January of each calendar year. 5) Allegation of Compliance: 12/27/23	
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs	E 037		12/27/23

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E 037	Continued From page 18 at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.	E 037		

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E 037	Continued From page 19 (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.	E 037		

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E 037	Continued From page 20 (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting	E 037		

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E 037	Continued From page 21 equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2	E 037		

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E 037	Continued From page 22 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure staff receive initial Emergency Preparedness (EP) training for 1 of 2 new employees (licensed practical nurse #7) and annual EP training for 1 of 5 employees (certified nursing assistant #11). The findings included: Licensed Practical Nurse (LPN) #7 was hired by the facility on 10/10/23 and had not received initial EP training. Certified Nursing Assistant #11 had not received annual EP training. On 11/16/23, surveyor spoke with the Administrator and requested evidence of initial EP training for LPN #7 who was hired on 10/10/23; the Administrator was unable to provide evidence of the training. On 11/16/23, surveyor spoke with the Administrator and requested evidence of annual EP training for CNA #11; the Administrator was unable to provide evidence of the annual training for CNA #11. The Administrator was unable to provide a reason for the lack of trainings as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of facility staff not receiving initial and annual EP training.	E 037	1) The center will provide Emergency Preparedness Plan (EPP) training to all current staff members and all new hires. 2) The center identified that the EPP had not been consistently reviewed with all current staff and newly hired staff members. The NHA/designee will ensure that the plan is reviewed with all newly hired staff members upon hire and all staff annually in January of each calendar year. 3) The VP of Operations will re-educate the Administrator on the need to educate staff members on the EPP. 4) The NHA/designee will ensure the training plan is reviewed by the QA committee in January of 2024 to ensure the training plan is reviewed in January of each calendar year. 5) Allegation of Compliance: 12/27/23	

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E 037	Continued From page 23 No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 037		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039		12/27/23

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E 039	Continued From page 24 (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 25 community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and	E 039		

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E 039	Continued From page 26 maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and	E 039		

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E 039	Continued From page 27 maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop	E 039		

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E 039	Continued From page 28 exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.	E 039		

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E 039	Continued From page 29 *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is	E 039		

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E 039	Continued From page 30 community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or	E 039		

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E 039	Continued From page 31 workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to participate in an annual full-scale Emergency Preparedness (EP) exercise. The findings included:	E 039	1) The center will organize a Full Scale Exercise of the Emergency Preparedness Plan (EPP). 2) The center identified that the center had not participated in a Full Scale Exercise annually. The NHA/designee will	

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E 039	Continued From page 32 The facility staff failed to participate in an annual full-scale EP exercise. On 11/16/23 at 9:30 AM, a review of the facility EP Plan was conducted with the Administrator and Maintenance Director. The most recent full-scale exercise was completed on 5/12/22. The Administrator acknowledged this was the most recent full-scale EP exercise and was unable to provide evidence that the facility had coordinated with outside EP agencies to schedule a full-scale exercise. The Administrator was unable to provide a reason for the lack of a full-scale exercise as they were only recently employed by the facility. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of the facility failing to participate in an annual full-scale EP exercise. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	E 039	ensure that the center participates in a Full Scale Exercise annually each year to remain in compliance. 3) The VP of Operations will re-educate the Administrator on the need to participate in a Full Scale Exercise with the Healthcare Coalition annually by 12/27/2023. 4) The NHA/designee will coordinate and schedule a Full Scale Exercise of the EPP. 5) Allegation of Compliance: 12/27/23	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 11/13/23 through 11/16/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Eight (8) complaints were investigated during the survey: 1. VA00060019 - Compliant with regulations	F 000		

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F 000	Continued From page 33 2. VA00059998 - Non-compliant with regulations 3. VA00059988 - Non-compliant with regulations 4. VA00059957 - Non-compliant with regulations 5. VA00059953 - Non-compliant with regulations 6. VA00059918 - Compliant with regulations 7. VA00059911 - Non-compliant with regulations 8. VA00059296 - Compliant with regulations The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 89 at the time of the survey. The survey sample consisted of 22 current resident reviews and 4 (four) closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		12/27/23

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F 550	Continued From page 34 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview and facility document review the facility staff failed to respect residents' rights to a dignified existence for 1 of 22 residents, Resident #8. The findings included: For Resident #8 the facility staff failed to provide incontinence pads. Resident #8's face sheet listed diagnoses which included but not limited to multiple sclerosis, chronic pain syndrome, and pressure ulcer to sacral region. Resident #8's most recent minimum data set with an assessment reference date of 09/18/23	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. F550 1) The center provided incontinence	

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F 550	Continued From page 35 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #8's comprehensive care plan was reviewed and contained a care plan for " ... has alteration in elimination of bowel and bladder, diuretic use, incontinence." Interventions for this care plan included, "Use of briefs/pads for incontinence protection." Surveyor spoke with Resident #8 on 11/13/23 at 4:40 pm. Resident #8 stated to surveyor that they wished they could still use the incontinent pads that the facility used to provide. Resident #8 stated the staff doesn't place a pad under them anymore, "they just use a blanket or sheet folded up. If I want pads, I have to buy them myself, and I don't have much money." Surveyor asked resident if they use incontinent briefs and resident stated, "I do, but I'm a heavy wetter, and it leaks through." Surveyor spoke with certified nurse's aide (CNA) #13 on 11/16/23 at 10:20 pm. Surveyor asked CNA #13 if the facility has incontinence pads, and CNA #13 stated they do not. Surveyor asked CNA #13 what they use, and CNA #13 stated, "We'll use a blanket if we're in a bind." Surveyor spoke with Resident #8 on 11/16/23 at 10:30 am. Surveyor asked Resident #8 if it bothers them to have a blanket used as an incontinence pad, and Resident #8 stated, "Yeah, it bothers me, I don't like laying on a wet blanket. I stay wet constantly because I leak all the time. I don't have the money to keep buying pads." Surveyor observed a folded blanket underneath	F 550	supplies per resident #8 preference on 12/20/23. 2) The center identified current incontinent residents and new admissions with incontinence to be at risk. The DON/Designee reviewed the current incontinent resident's incontinence management regimen on or before 12/27/23 and determined appropriate incontinence management. 3) The DON/Designee will re-educated the licensed nurses and CNAs on resident's rights and incontinence management on or before 12/27/23. 4) The DON/Designee will monitor 5 residents incontinence management regimen weekly times 4 weeks. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 550	Continued From page 36 resident in the bed. Surveyor requested and was provided with a facility policy entitled, "Resident Rights" which read in part, "The Resident has right to a dignified existence, self-determination, and communication with, and access to, persons, and services inside and outside the Facility." The concern of not providing incontinence pad for Resident #8 was discussed with the administrator, chief nursing officer and regional vice-president of operations on 11/16/23 at 5 pm. No further information was provided prior to exit.	F 550		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and	F 563		12/27/23

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F 563	Continued From page 37 (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to allow family visitation for 1 of 4 closed record reviews, Resident #92. The findings included: The facility staff failed to allow the family to stay with the Resident at the facility after the resident had a change in condition. Resident #92's diagnoses included but were not limited to, Alzheimer's, dementia, and muscle weakness. Section C (cognitive patterns) of Resident #92's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/16/23 included a brief interview for mental status (BIMS) summary score of 3 out of a possible 15 points. Resident #92's comprehensive care plan included the focus areas sometimes shows behavior symptoms, at risk for pressure ulcers, requires assistance with one or more staff for activity of daily living, and difficulty with independent feeding.	F 563	F563 1) Resident #92 was discharged on 10/20/23 to a hospice house. 2) The center identified current residents. No other residents were identified at this time. 3) The Administrator/Designee re-educated the facility staff regarding the center's visitation guidance on or before 12/27/23. 4) DON/Designee will monitor adherence to the visitation policy weekly for 4 weeks. Findings will be review during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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Resident #92's clinical record included an order for Hospice effective 10/13/23.

The facility staff provided the survey team with a copy of the Hospice documentation. On 10/19/23, the Hospice nurse documented the patients immediate needs were comfort and support for patient and family and the facility staff had told the family they could not stay with this resident as it was against the facility's policy.

The facility staff provided the surveyor with a copy of their document titled, "Nursing Home Resident Rights." This document read in part, "...You have the following rights...To have visitors at any time, as long as you wish to see them, as long as the visit does not interfere with the provision of care and privacy rights of other residents..."

On 11/14/23 at 1:40 p.m., during an interview with the current interim Director of Nursing (DON) this staff stated they had received a call from Licensed Practical Nurse (LPN) #1 (no longer employed) and stated the family wanted to stay overnight at the facility. The DON stated they could not remember who they called but someone had told them their policy was no overnight stays. The DON stated before they had a chance to move this resident the resident had been discharged.

On 11/15/23 at 1:27 p.m., during an interview with Certified Nursing Assistant (C.N.A.) #8 this staff stated the family wanted to spend the night, but they don't allow visitors to stay.

On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator, Regional Vice

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F 563	Continued From page 39 President of Operations, and Chief Nursing Officer. The surveyor asked about family members spending the night with Resident #92. The Administrator stated if you are admitted on Hospice, you would be in a room by yourself (private) so the family could stay. If you become Hospice, we ask the roommate to move we would not want to move the Hospice patient. The Administrator stated by not being here I can't really say I don't know all the in's and out's, but I would think it would be done as quickly as possible. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 563		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		12/27/23

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F 580	Continued From page 40 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, the facility staff failed to notify the MD and/or RP of significant changes in the resident's physical, mental or psychosocial status for 3 of 22 residents sampled. Resident # 19, 26, 64. The findings included:	F 580	F580 1) Resident #19 expired 10/29/23 and #26 was discharged on 11/19/23. 2) Residents identified with change in condition are being reviewed during the clinical meeting by the DON/Designee to confirm notification of physician and resident representative has been	

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F 580	Continued From page 41 1. For resident # 19, the facility staff failed to notify the physian and responsible party of a fall that occurred 10/6/23. This was a closed record review. Resident #19's diagnoses included but were not limited to, unspecified dementia, angina, cognitive communication deficit, moderate protein calorie malnutrition, Alzheimer's with late onset, adult failure to thrive, muscle weakness (generalized), essential hypertension, and paroxysmal atrial fibrillation. The most recent minimum data set (MDS) assessment assigned the resident a brief interview for mental status score (BIMS) of 3, indicating severe cognitive impairment. There was a progress note in the clinical record with an effective date of 10//6/23 at 2:34 AM that indicated resident fell at 2:25 AM. The resident was assessed for injury and assisted back to bed. There was no indication in the note that the physician or responsible party were notified of the fall. There were no follow up notes during the day shift to indicate the responsible party or physician were notified later. The surveyor was unable to locate a progress note from the physician to indicate they were notified of the fall on 10/6/23. The surveyor spoke with the Administrator and requested copies of all provider notes for the month of October 2023 on 11/16/23 at 8:34 AM. No notes were provided prior to the exit conference. The surveyor requested and received the policy entitled, "Falls Prevention Program", there was no	F 580	completed. 3) The DON/Designee re-educated the licensed nurses regarding notification of change in condition by 12/27/23. 4) The DON/Designee will audit change in condition notification during the clinical meeting to verify physician, resident and/or responsible representative weekly for 4 weeks. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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effective date noted. Page 13 of the policy was entitled, "Steps to Follow When a Fall Occurs", and read in part, "2. Notify Doctor and family."

On 10/16/23 at 8:41 AM the surveyor interviewed LPN #10 who documented the fall. They stated that they did not recall notifying the physician or the responsible party.

The survey team met with the Administrator, Regional Vice President and Chief Nursing Officer 11/16/23 at 5:20 PM and this concern was discussed.

No further information was presented to the survey team prior to the exit conference.

2. For resident # 26, the facility staff failed to notify the responsible party or the physician of an injury of unknown origin.

Resident # 26's diagnoses included but were not limited to, hypertension, Alzheimer's Disease, anxiety, depression, unspecified mood disorder, diabetes and chronic obstructive pulmonary disease.

Resident # 26's most recent MDS assigned them a BIMS score of 4 indicating severe cognitive impairment.

During a review of the clinical record, a note dated 9/8/23 at 1:01 PM read in part, "Resident continues to complain of right shoulder and arm pain. New order given to sent to ED (emergency department) for x-ray of arm and shoulder." The note also indicated that the physician and the responsible party had been notified. On 9/8/23 at 2200 a note was entered and read in part,

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"Returned following x-ray of right elbow and shoulder due to complaints of pain. No previous injury reported. Imaging shows possible fracture of right humerus. There was no indication that the physician or the responsible party were notified of the fracture.

On 11/15/23 at approximately 2:00 PM, this surveyor spoke with resident # 26's Physician's Assistant (PA) who stated that they nor the resident's primary care physician were notified of the fracture until several days after the fact. They stated that they documented this fact in a progress note. Surveyor asked where to locate the note and they stated, "I couldn't tell you but they should be able to get it for you."

On 11/15/23 at approximately 3:00 PM, this surveyor spoke with resident # 26's Power of Attorney (POA). When asked if they were notified of the fracture, they stated, "No. Nobody told me. I knew they were sending (resident) to the hospital to have it looked at, but never heard what the end result was."

Surveyor requested and received the policy entitled, "Resident Abuse- Injuries of Unknown Origin", which read in part,"Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no known cause." Under the heading "Procedure" read in part, "3. Notifications MUST be made to the following: A. Resident's responsible party B. Physician."

On 11/15/23 at 3:30 PM the survey team met with the Administrator, Chief Nursing Officer and Regional Vice President. This concern was discussed and a copy the progress note referred to by the PA was requested. The note was

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F 580	Continued From page 44 provided. It was dated 9/14/23 and read in part, "Patient seen on rounds 9/14/23 for right humerus fracture. Myself or Dr. (name omitted) were not made aware of the ER visit or fracture and patient was not placed on rounds for us to evaluate the patient until today. We have both been in the building, myself on Monday 9/11/23 and Dr. (omitted) on Tuesday 9/12/23 and neither of us was made aware that the patient had a fracture." The survey team met with the Administrator, Regional Vice President and Chief Nursing Officer on 11/16/23 5:20 PM and this concern was discussed. No further information was provided to the survey team prior to the exit conference.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		12/27/23

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F 583	Continued From page 45 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on documents received at the Office of Licensure and Certification (OLC), facility staff failed to ensure the right to secure and confidential medical records for 1 of 22 residents sampled (Resident #68). Resident #68 was admitted to the facility with diagnoses which included Alzheimer's dementia, hypertension, congestive heart failure, dysphagia, recurrent falls, and diabetes mellitus type 2 with neuropathy. On the Minimum Data Set assessment with Assessment Reference Date 10/6/23, the resident scored 9/15 on the brief interview for mental status, indicating impairment in daily decision-making skills, and was assessed as without signs of delirium, psychosis, or behaviors affecting care of self or others. On 11/15/2023, a complaint was received in OLC which included a screen shot of a resident's progress note in the electronic clinical record. The complainant wrote that the note was proof of	F 583	F583 1) Resident #68 responsible representative will be notified of the privacy/confidentiality records breach on or before 12/27/2023 by the Administrator. 2) The center identified current residents to be at risk. The center interdisciplinary team (IDT) will interview the current residents or responsible representatives regarding knowledge of breaches in HIPPA on or before 12/27/23. 3) The Administrator/Designee re-educated facility staff on HIPPA and Personal Privacy/Confidentiality of Records on 11/27/2023 and 11/28/2023. 4) The Administrator/Designee will interview 5 staff members per week regarding HIPPA/ Privacy and Confidentiality times 4 weeks. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed.	

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F 583	Continued From page 46 an allegation of failure to report an incident (the progress note described an incident, but did not address the complainant's allegation). The complaint form including the progress note was faxed to OLC on 11/15/2023. This was not an appropriate use of the resident's record. The surveyor reported the concern with confidentiality and inappropriate use of clinical records to the administrator and RVPO during a summary conference on 11/16/2023. Neither denied the use of clinical records was inappropriate.	F 583	5) AOC: 12/27/23	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		12/27/23

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F 604	Continued From page 47 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility document review the facility staff failed to provide the ongoing re-evaluation of the need for physical restraints for 1 of 22 sampled residents. Resident #33. The findings were: For Resident #33, the facility staff failed to reassess the risk for elopement/wandering prior to applying a Wander Guard monitor. The resident's Admission Record listed their diagnoses to included, but were not limited to multiple sclerosis, dementia, Alzheimer's disease, Parkinson's disease with dyskinesia, and type 2 diabetes mellitus. On the quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 10/11/23, the resident scored a 10 out of 15 on the brief interview for mental status. Section P (Restraints and Alarms) read the resident had a wander/elopement alarm daily. Resident #33's clinical record was reviewed. One (1) Elopement Risk Assessment document was found, dated 04/03/23 and read the resident was not at risk for elopement. There were no other elopement risk assessments found. The	F 604	F604 1) Resident #33 elopement assessment was updated on 11/15/2023 indicating high risk for elopement by the licensed nurse. 2) The DON/Designee will review current residents identified as at risk for elopement with orders for wanderguard use to ensure re-evaluation of risk completed per policy by 12/27/23. 3) The DON/Designee will re-educate licensed nurses and interdisciplinary team members (IDT) on residents at risk for elopement and Resident's Right to be free from Physical Restraints, elopement risk management guidance and the wanderguard system on or before 12/27/23. 4) The DON/Designee will monitor 3 residents at risk for elopement per week times 4 weeks to ensure compliance with elopement risk guidance and wanderguard use guidance. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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Treatment Administration Record (TAR) for November 2023 was reviewed and staff documented the Wander Guard was checked each shift. A provider's order for a Wander Guard to right ankle was dated 09/30/23. A nurse's progress note dated 09/20/23 read, "Wander Guard to right ankle - placement checked Q (every) shift". The nurse who wrote the progress note was interviewed via phone on 11/16/23 at 1:33 p.m. The nurse stated she worked shifts at the facility occasionally, as a fill-in, and was unable to recall Resident #33 or applying a Wander Guard.

On 11/15/23 at 9:38 a.m. this surveyor, along with LPN #8, observed Resident #33 who was wearing a Wander Guard on his right ankle. The resident was sitting up in a wheelchair with his eyes closed. When asked how staff were testing the Wander Guard, the resident replied, "I don't know." His eyes remained closed. The administrator and chief nursing officer (CNO) was informed of this restraint concern on 11/15/23.

On 11/16/23 at 8:48 a.m., this surveyor and the CNO spoke with the facility's MDS Coordinator regarding Resident #33's Wander Guard and elopement risk assessments. Although the MDS Coordinator provided documentation showing the resident had multiple orders for a Wander Guard over the past several years, both the MDS Coordinator and the CNO acknowledged there was no evidence of an elopement risk assessment after April 2023 until the one completed yesterday, after the surveyor asked about the assessments. The MDS Coordinator provided an Elopement Risk Assessment, dated 11/15/23, which read Resident #33 was at risk for elopement. The CNO reported the resident has

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F 604	Continued From page 49 not tried to elope but verbalizes wanting to leave. A certified nursing assistant's hand-written statement dated 11/16/23 was provided. The CNA wrote that Resident #33 mentioned leaving to go home, needing to go the store for various things, and needing to leave to visit his brother. The resident voiced these statements "at least every other day." The CNA wrote that any time staff tried to redirect Resident #33 from wanting to leave, "it worsens his behavior." This concern was discussed with the administrator, CNO, and regional vice president of operations during an end of day meeting on 11/16/23. No further information was provided prior to the exit conference.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD GALAX, VA 24333

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F 609	Continued From page 50 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review the facility staff failed to ensure injuries of unknown origin were reported for 1 of 22 current residents sampled and one of 4 closed records sampled. Resident #19 and Resident #26. The findings included: 1. For resident # 19, the facility staff failed to report a right hip fracture that was identified on 10/13/23. This was a closed record review. Resident # 19's diagnoses included but were not limited to, unspecified dementia, cognitive communication deficit, generalized anxiety, Alzheimer's with late onset, insomnia, weakness, history of falling. Resident # 19's Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/20/23 assigned the resident a Brief Interview for Mental Status (BIMS) score of 3, indicating they were severely cognitively impaired. The resident was also coded as dependent for Activities of Daily Living (ADL's) and mobility.	F 609	F609 1) Resident #19 no longer resided in the facility at time of survey. Resident #26 discharged from the facility on 11/19/23. Investigation and FRI completed on 11/15/23. 2) Current resident event reports for November were reviewed by the NHA/designee for potential reportable events. None noted. 3) The Administrator/Designee will re-educate facility staff on reporting Resident Abuse/Significant Events on or before 12/27/23. 4) The Administrator/Designee will monitor 3 resident records weekly times 4 weeks for potential reportable events. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 609	Continued From page 51 The clinical record was reviewed. A progress note dated 10/13/23 at 8:06 AM read, "Situation : xray results back show fracture of femoral neck fracture of right hip Background : found in floor on 10/06/2023 Assessment : pain to right hip Response : called md on call new order send to er." A progress note was located for 10/6/23 at 2:34 AM that read, "Situation : Staff alerted me to residents room at 02:25am (they) was found with (their) trunk lying beside bed and legs tucked underneath the bed. (They) is awake and alert, states (they) is unsure what happened. Background : Resident is a 90 y.o. with dementia and mild cases of confusion, h/x of falls and generalized weakness. Assessment : Resident appears baseline status prior to any incident, is able to answer most questions with occasional confusion pre existing prior to possible incident. is verbal and able to follow commands, neurological checks remain at baseline, denies any pain or injury at this time, Vital signs remain within normal limits BP 148/86, Temp. 98.4 tympanic, Pulse 83, 18 RR no visual injuries noted. Skin appears intact without breaks or bruising at this time. Resident states does not know what happened. Response : Two CNA's and myself sat patient upright and assisted back in bed, appears as normal baseline prior to incident. Fall protocol initiated, resident is back in his bed lying supine with no complaints at this time." There were no notes in between these two notes to indicate resident was having pain or had another fall. There was no explanation in the notes as to why or when the x-ray was ordered. There was an order entered on 10/11/23 that read, " X-ray rt hip two views and pelvis one time only for Rt. hip pain from previous fall." Resident # 19 was readmitted to the facility on 10/14/23	F 609		

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F 609	Continued From page 52	F 609		

after it was determined they were not a surgical candidate.

On 11/16/23 at 8:41 AM this surveyor interviewed LPN # 10 who was caring for resident #19 the morning 10/6/23 when resident # 19 fell. They stated that they assessed resident and there was no indication of any injuries so they and 2 other staff members assisted resident back to bed.

This surveyor requested and received a copy of the policy entitled, "Resident Abuse- Injuries of Unknown Origin" with a revision date of 4/2020. The policy read in part, "Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4. The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 7. All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols."

This surveyor met with the Administrator on 11/16/23 at approximately 11:00 AM and asked for the Facility Reported Incident (FRI) for resident # 19's right hip fracture October 13, 2023. They stated they could not locate an FRI for this resident in October. Surveyor asked if they would have expected one to be done for a hip fracture identified a week after the last fall, and they stated, "I would, but I wasn't here at the time and can't say what the previous Administrator did or didn't do."

The survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer on 11/16/23 at 5:20 PM and this concern was discussed.

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F 609	Continued From page 53 No further information was provided to the survey team prior to the exit conference. 2. For resident # 26 the facility staff failed to report a fracture of the right humerus that was identified 9/8/23. Resident # 26's diagnoses included but were not limited to, hypertension, Alzheimer's Disease, anxiety, depression, unspecified mood disorder, diabetes and chronic obstructive pulmonary disease. Resident # 26's most recent MDS assigned them a BIMS score of 4 indicating severe cognitive impairment. During a review of the clinical record, a note dated 9/8/23 at 1:01 PM read in part, "Resident continues to complain of right shoulder and arm pain. New order given to sent to ED (emergency department) for x-ray of arm and shoulder." On 9/8/23 at 2200 a note was entered that read in part, "Returned following x-ray of right elbow and shoulder due to complaints of pain. No previous injury reported. Imaging shows possible fracture of right humerus." This surveyor was not able to locate an explanation in the progress notes as to how the injury occurred. On 11/15/23 at 3:30 PM the survey team met with the Administrator, Chief Nursing Officer and Regional Vice President. This concern was discussed at that time. The Administrator is newly employed and states they were not aware of this incident. This surveyor requested and received a copy of the policy entitled, "Resident Abuse- Injuries of	F 609		

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F 609	Continued From page 54 Unknown Origin" with a revision date of 4/2020. The policy read in part, "Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4. The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 7. All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols." 11/16/23 The Administrator presented a packet to the surveyor with what information they could locate in the record as well as staff statements and stated that they were investigating the injury and would be submitting an FRI. No further information was provided to the survey team prior to the exit conference.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		12/27/23

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F 610	Continued From page 55 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, facility staff failed to initiate a thorough investigation of an injury of unknown origin for 1 of 22 active residents sampled and 1 of 4 closed records. Resident # 19 and Resident # 26. The findings included: 1. For resident # 19 the facility staff failed to investigate a right hip fracture that was identified October 13, 2023. This was a closed record review. Resident # 19's diagnoses included but were not limited to, unspecified dementia, cognitive communication deficit, generalized anxiety, Alzheimer's with late onset, insomnia, weakness, history of falling. Resident # 19's Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/20/23 assigned the resident a Brief Interview for Mental Status (BIMS) score of 3, indicating they were severely cognitively impaired. The resident was also coded as dependent for Activities of Daily Living (ADL's) and mobility. The clinical record was reviewed. A progress note dated 10/13/23 at 8:06 AM read, "Situation : xray results back show fracture of femoral neck fracture of right hip Background : found in floor on 10/06/2023 Assessment : pain to right hip Response : called md on call new order send to er." A progress note was located for 10/6/23 at	F 610	F610 1) Resident #19 no longer resided in the facility at time of survey. Resident #26 discharged from the facility on 11/19/23. Investigation and FRI completed on 11/15/23. 2) Current resident event reports for November were reviewed by the NHA/designee for potential reportable events with investigation completed. No issues noted. 3) The Administrator/Designee will re-educate facility staff on reporting Resident Abuse/Significant Events and the investigation process on or before 12/27/23. 4) The Administrator/Designee will monitor 3 resident records weekly times 4 weeks for potential reportable events. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 610	Continued From page 56 2:34 AM that read, "Situation : Staff alerted me to residents room at 02:25am (they) was found with (their) trunk lying beside bed and legs tucked underneath the bed. (They) is awake and alert, states (they) is unsure what happened. Background : Resident is a 90 y.o. with dementia and mild cases of confusion, h/x of falls and generalized weakness. Assessment : Resident appears baseline status prior to any incident, is able to answer most questions with occasional confusion pre existing prior to possible incident. is verbal and able to follow commands, neurological checks remain at baseline, denies any pain or injury at this time, Vital signs remain within normal limits BP 148/86, Temp. 98.4 tympanic, Pulse 83, 18 RR no visual injuries noted. Skin appears intact without breaks or bruising at this time. Resident states does not know what happened. Response : Two CNA's and myself sat patient upright and assisted back in bed, appears as normal baseline prior to incident. Fall protocol initiated, resident is back in his bed lying supine with no complaints at this time." There were no notes in between these two notes to indicate resident was having pain or had another fall. There was no explanation in the notes as to why or when the x-ray was ordered. There was an order entered on 10/11/23 that read, " X-ray rt hip two views and pelvis one time only for Rt. hip pain from previous fall." Resident # 19 was readmitted to the facility on 10/14/23 after it was determined they were not a surgical candidate. On 11/16/23 at 8:41 AM this surveyor interviewed LPN # 10 who was caring for resident #19 the morning 10/6/23 when resident # 19 fell. They stated that they assessed resident and there was no indication of any injuries so they and 2 other	F 610		

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F 610	Continued From page 57 staff members assisted resident back to bed. This surveyor requested and received a copy of the policy entitled, "Resident Abuse- Injuries of Unknown Origin" with a revision date of 4/2020. The policy read in part, "Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4. The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements as deemed necessary." This surveyor met with the Administrator on 11/16/23 at approximately 11:00 AM and asked for the Facility Reported Incident (FRI)/investigation for resident # 19's right hip fracture October 13, 2023. They stated they could not locate an FRI for this resident in October. Surveyor asked if they would have expected one to be done for a hip fracture identified a week after the last fall, and they stated, "I would, but I wasn't here at the time and can't say what the previous Administrator did or didn't do." The survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer on 11/16/23 at 5:20 PM and this concern was discussed. No further information was provided to the survey team prior to the exit conference. 2. For resident # 26 the facility staff failed to report a fracture of the right humerus that was	F 610		

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F 610	Continued From page 58 identified 9/8/23. Resident # 26's diagnoses included but were not limited to, hypertension, Alzheimer's Disease, anxiety, depression, unspecified mood disorder, diabetes and chronic obstructive pulmonary disease. Resident # 26's most recent MDS assigned them a BIMS score of 4 indicating severe cognitive impairment. During a review of the clinical record, a note dated 9/8/23 at 1:01 PM read in part, "Resident continues to complain of right shoulder and arm pain. New order given to sent to ED (emergency department) for x-ray of arm and shoulder." On 9/8/23 at 2200 a note was entered that read in part, "Returned following x-ray of right elbow and shoulder due to complaints of pain. No previous injury reported. Imaging shows possible fracture of right humerus." This surveyor was not able to locate an explanation in the progress notes as to how the injury occurred. On 11/15/23 at 3:30 PM the survey team met with the Administrator, Chief Nursing Officer and Regional Vice President. This concern was discussed at that time. The Administrator is newly employed and states they were not aware of this incident. Surveyor requested a copy of the FRI/investigation. This surveyor requested and received a copy of the policy entitled, "Resident Abuse- Injuries of Unknown Origin" with a revision date of 4/2020. The policy read in part, "Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4.	F 610		

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F 610	Continued From page 59 The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements as deemed necessary." 11/16/23 The Administrator presented a packet to the surveyor with what information they could locate in the record as well as staff statements and stated that they were investigating the injury and would be submitting an FRI as there was no evidence that one had been done. No further information was provided to the survey team prior to the exit conference.	F 610		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility for 1 of 22 residents in the survey sample, Resident #86.	F 624	F624 1) Resident #86 currently resides at the center. No discharge date set at this time. The interdisciplinary team (IDT) will review discharge needs with the resident prior to discharge to ensure a safe discharge	12/27/23

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F 624	Continued From page 60 The findings included: For Resident #86, the facility staff failed to provide the resident with discharge instructions or medication prescriptions prior to a planned discharge home. Resident #86's diagnosis list indicated diagnoses, which included, but not limited to Pressure Ulcer of Right Buttocks, Open Wound of Abdominal Wall, Ventral Hernia with Obstruction, Type 2 Diabetes Mellitus, and Muscle Weakness. The quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/23/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating Resident #86 was cognitively intact. The resident was coded as being dependent with personal hygiene and toileting hygiene. Resident #86 was coded as having one stage 4 pressure ulcer and a surgical wound. Resident #86's comprehensive person-centered care plan included a focus area stating, "I would like assistance in planning my next steps to be able to go home safely when my care/rehab goals are met" with an intervention stating, "Help me with developing transition strategies that will make my leaving go smoothly." According to Resident #86's clinical record, the resident was discharged home on 11/01/23. A nursing progress note dated 11/01/23 11:29 AM stated "10:30 am Resident left with all [his/her] belongings with [spouse] by [his/her] side, staff assisted this pt [patient] into [his/her] car. Pt has to return to get [his/her] prescriptions for [his/her]	F 624	plan. 2) The SSD reviewed current residents with plans to discharge to the community to determine safe discharge needs with the Interdisciplinary team (IDT). 3) The Administrator/Designee re-educated the SSD and IDT on the interdisciplinary discharge summary and Discharge/Transfer planning guidance on or before 12/27/23. 4) The SSD/Designee will monitor resident discharges/transfers to ensure a safe interdisciplinary team (IDT) discharge plan prior to the scheduled discharge weekly times 4 weeks. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 624	Continued From page 61 medications." Surveyor reviewed Resident #86's clinical record and was unable to locate evidence of discharge instructions provided to the resident prior to discharge home on 11/01/23. On 11/13/23 at 5:30 PM, surveyor spoke with Resident #86 who stated when they were discharged from the facility on 11/01/23, they did not speak to anyone about discharge, did not receive any discharge papers, instructions, medications, or medication prescriptions, only a prescription for a walker. Resident #86 stated facility staff were aware of their discharge and wheeled them out to their car when leaving. The resident stated after leaving the facility, they went to their community pharmacy and the pharmacy had to contact the facility to obtain prescriptions. The resident stated they missed all their medications on the day of discharge. On 11/14/23 at 11:00 AM, surveyor spoke with the Social Services Director (SSD) regarding Resident #86's planned discharge. SSD stated they were recently employed by the facility and Resident #86's discharge was their first planned discharge. SSD stated they were unaware they were supposed to assemble the discharge packet, and this was the reason the resident did not receive discharge instructions or medication prescriptions. SSD provided copies of physician signed medication prescriptions dated 10/30/23 for Furosemide, Atorvastatin Calcium, Montelukast Sodium, Amlodipine, Gabapentin, and Potassium Chloride which were not provided to the resident. On 11/14/23 at 12:01 PM, surveyor spoke with	F 624		

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F 624	Continued From page 62 licensed practical nurse (LPN) #7, the nurse present at the time of Resident #86's discharge. LPN #7 stated they were aware Resident #86 was discharging but did not have the discharge packet and thought the SSD went over the discharge instructions and packet with the resident. LPN #7 stated the SSD had the resident's orders. Surveyor requested and received the facility policy titled "Discharge Planning Documentation" which read in part: " ...4. At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: A. Current diagnosis B. Rehabilitation potential C. Summary of prior treatment D. Physician's orders for immediate care E. Pertinent social information F. Community referrals as needed (e.g., home health, mental health, adult day care, etc.) ..." On 11/14/23 at 4:32 PM, the survey team met with the administrator, regional vice president of operations, and the chief nursing officer and discussed the concern of staff failing to provide discharge instructions and medication prescriptions to Resident #86 at discharge home. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 624		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		12/27/23

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F 655	Continued From page 63 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655		

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F 655	Continued From page 64 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record, facility document review the facility staff failed to develop a baseline care plan within 48 hours of admission for 4 of 22 residents sampled. Resident #64, #77, 294, and #86. The findings include: 1. For resident # 64, the facility staff failed to develop a baseline care plan when the resident was admitted to the facility. Resident # 64's diagnoses included, but were not limited to, unspecified dementia, chronic atrial fibrillation, age related osteoporosis, essential hypertension, chronic pain syndrome, and presence of a cardiac pacemaker. Section C (cognitive patterns) of Resident # 64's most recent minimum data (MDS) assessment with an assessment reference date (ARD) of 10/20/23 included a brief interview for mental status (BIMS) summary score of 4 out of a possible 15 points, indicating severe cognitive impairment. During a review of the clinical record the surveyor was unable to locate a baseline care plan. On 11/15/23 during a meeting with the Administrator, Chief Nursing Officer and Regional Vice President of operations, the surveyor requested to review the baseline care plan for resident # 64. The Administrator stated, "We've	F 655	F655 1) Resident #64 baseline care plans were completed and reviewed with resident representative. Resident #77 not listed on survey resident sample identifier list. Resident #294 baseline care plan completed on 11/22/23 with copy provided to resident. Resident #86 baseline care plan completed on 11/22/23 with copy provided to resident. 2) The DON/Designee reviewed the November and December new admission resident records to validate resident centered baseline care plans will be completed with a copy provided to the resident or responsible representative by 12/27/23. 3) The DON/Designee re-educated the IDT and licensed nurses on the resident centered baseline care plan guidance on by 12/27/23. 4) The DON/Designee will monitor new admissions weekly times 4 weeks to validate resident centered baseline care plans are completed with a copy provided to the resident or responsible representative. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 655	Continued From page 65 determined that it was not done." No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For resident # 77, the facility staff failed to develop a baseline care plan when the resident was admitted to the facility. Resident # 77's diagnoses included, but were not limited to, unspecified intracranial injury without loss of concsiousness, chronic obstructive pulmonary disorder, restelessness and agitation, unspecified mood disorder, unspecified dementia, generalized anxiety. Section C (cognitive patterns) of Resident # 77's most recent minimum data (MDS) assessment with an assessment reference date (ARD) of 8/23/23 included a brief interview for mental status (BIMS) summary score of 6 out of a possible 15 points, indicating severe cognitive impairment. During a review of the clinical record the surveyor was unable to locate a baseline care plan. On 11/15/23 during a meeting with the Administrator, Chief Nursing Officer and Regional Vice President of operations, the surveyor requested to review the baseline care plan for resident # 64. The Administrator stated, "We could not locate a baseline care plan." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 655		

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F 655	Continued From page 66	F 655		

3. For Resident #294 the facility staff failed to develop a baseline care plan for intravenous antibiotic and restraint usage.

Resident #294's face sheet listed diagnoses which included but not limited to sepsis and malignant neoplasm of pancreatic duct.

Resident #294's minimum data set (MDS) was not yet completed; however, Resident # 294 was alert and oriented to person, place, time, and situation.

Resident #294's clinical record was reviewed and contained a physician's order summary which read in part, "Merrem Intravenous Solution Reconstituted 500 mg (Meropenem). Use 2000 mg intravenously every 8 hours for sepsis for 5 days." Resident #294's clinical record also contained an "Informed Consent for the use of Physical Restraints" form.

Surveyor could not locate a baseline care plan in Resident #294's clinical record.

Surveyor spoke with MDS coordinator on 11/15/23 at 8:30 am regarding Resident #294's baseline care plan. MDS coordinator stated that baseline care plans are completed on paper and located in the paper chart.

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F 655	Continued From page 67 Surveyor reviewed Resident #294's paper chart but could not locate a baseline care plan. Unit manager stated to surveyor that baseline care plans are located in the MDS office, not in the chart. During a meeting with the administrator, chief nursing officer, and regional vice president of operations on 11/15/23 at 3:30 pm, when asked about baseline care plans, the chief nursing office stated, "I don't think they've been doing them, that's what they told me." Surveyor requested and was provided with a facility policy entitled "Care Plan" which read in part, "Procedure: 2. A Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care Plan is completed." The concern of not developing a baseline care plan was discussed with the administrator, chief nursing officer, and regional vice president of operations on 11/16/23 at 5 pm. No further information was provided. 4. For Resident #86, the facility staff failed to develop and implement a baseline care plan within 48 hours of admission. Resident #86's diagnosis list indicated diagnoses, which included, but not limited to Pressure Ulcer of Right Buttocks, Open Wound of Abdominal Wall, Ventral Hernia with Obstruction, Type 2 Diabetes Mellitus, and Muscle Weakness.	F 655		

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F 655	Continued From page 68 According to Resident #86's demographic face sheet, the resident was admitted to the facility on 11/02/23. An "Admission Data Collection Form" dated 11/02/23 documented the resident as being alert and independent in decisions regarding tasks of daily living. On 11/15/23, surveyor reviewed Resident #86's clinical record and was unable to locate a completed baseline care plan following admission on 11/02/23 or a current comprehensive person-centered care plan. On 11/15/23 at 8:39 AM, surveyor spoke with the minimum data set (MDS) coordinator who reviewed Resident #86's clinical record and was also unable to locate the baseline care plan. MDS Coordinator stated Resident #86 should have a baseline care plan initiated by the admitting nurse and completed the following day by the IDT (interdisciplinary team). MDS Coordinator stated they would check with medical records to try and locate the document. On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Regional Vice President of Operations (RVPO), and Chief Nursing Officer (CNO) and discussed the concern of Resident #86 not having a baseline care plan initiated with admission. The CNO stated they did not think staff were doing baseline care plans at the time. Surveyor requested and received the facility policy titled "Care Plan" which read in part " ...2. A Baseline Care plan must be developed within 48 hours of admission to insure [sic] that the resident's needs are met appropriately until the Comprehensive Care Plan is completed ..."	F 655		

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F 655	Continued From page 69 No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (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 staff interview, clinical record review, and facility document review, the facility staff	F 657	F657	12/27/23

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F 657	Continued From page 70 failed to review and revise the comprehensive care plan for 3 of 22 residents sampled. Resident # 26, # 64, and # 33. The findings included: 1. For resident # 26, the facility staff failed to update the comprehensive care plan after a fall with injury and after an injury of unknown origin. Resident # 26's diagnoses included but were not limited to, hypertension, Alzheimer's Disease, anxiety, depression, unspecified mood disorder, diabetes and chronic obstructive pulmonary disease. Resident # 26's most recent MDS assigned them a BIMS score of 4 indicating severe cognitive impairment. During a review of the clinical record, a progress note dated 9/8/23 at 1:01 PM read in part, "Resident continues to complain of right shoulder and arm pain. New order given to sent to ED (emergency department) for x-ray of arm and shoulder." The note also indicated that the physician and the responsible party had been notified. On 9/8/23 at 2200 a note was entered and read in part, "Returned following x-ray of right elbow and shoulder due to complaints of pain. No previous injury reported. Imaging shows possible fracture of right humerus. There was no care plan update for the fracture in the clinical record. A progress note dated 10/01/2023 at 09:41 AM read in part, "found on floor in hallway. assessed for injury. quarter sized knot to back of head. ice pack applied to area. pearl. MAE. assisted up x2 staff. neuro checks initiated. MD and RP made	F 657	1) Resident #26 discharged on 11/19/2023. Resident #64 and #33 comprehensive care plans reviewed, updated and validated as complete by the MDS Coordinator on 10/16/23 and 10/24 respectively. 2) The MDS Coordinator will review current resident's comprehensive care plans during their quarterly assessment reference to validate that the care plans are updated and appropriate for the residents. 3) The DON/Designee will re-educated the center's interdisciplinary team (IDT) and licensed nurses on the comprehensive care plan by 12/27/23. 4) The MDS Coordinator will review 2 resident comprehensive care plans weekly x 4 weeks. Finding will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 657	Continued From page 71	F 657		

aware." There was no care plan update for this fall with injury located in the medical record.

On 11/16/2023 at 10:36 AM this surveyor met with the Administrator and asked for documentation that resident # 26's care plan had been reviewed and revised after each of these incidents. No documentation was provided, the Administrator confirmed there was no care plan update for either issue.

The surveyor requested and received a copy of the policy entitled, "Falling Stars Program". Page 13 of the packet entitled, "Steps to Follow When a Fall Occurs" read in part, "7. Establish new interventions and place them on the care plan. 8. Implement interventions on care plan."

On 11/16/23 at 5:25 PM the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and this issue was discussed.

No further information was provided to the survey team prior to the exit conference.

2. For resident # 64 the facility staff failed to update the comprehensive care plan after a fall with injury.

Resident # 64's diagnoses included but were not limited to, dementia, chronic atrial fibrillation, age related osteoporosis, essential hypertension, and muscle weakness.

During a review of the clinical record, a progress note dated 10/14/2023 at 1:00 PM read in part, "Called to resident's room by CNA (Certified Nursing Assistant), found resident in floor lying on

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F 657	Continued From page 72 (their) left hip and side, stated (they) rolled out of bed onto the floor, nurse performed assessment and could not feel any abnormalities to hips, resident complained of pain all over and then that (their) back was torn into, Dr. Bonsu was called and received order to send to ER, ambulance called, and they arrived at 1:25pm. Resident loaded on stretcher and left at 1:37pm, vitals were obtained and stable, called report to (nurse) at (name omitted) hospital." Resident # 64 was readmitted to the facility 10/18/2023 at 4:49 PM according to a progress note which read in part, "Resident returned via stretcher transport. Resident pleasantly confused. VSS, messaged MD for orders for pain meds. Resident with DX of pelvic fx and left femoral neck fracture received 3 units of blood at hospital and eliquis on hold. Large purple/blue hematoma to left hip raised area. Resident assisted with all adls. Bruise observed to back of heel to right foot." There was no care plan update in the clinical record for the fall or the fractures. On 11/16/2023 at 10:36 AM this surveyor met with the Administrator and asked for documentation that resident # 64's care plan had been reviewed and revised after each of these incidents. No documentation was provided, the Administrator confirmed there was no care plan update for the fall or fractures on 11/16/23 at 1:20 PM. The surveyor requested and received a copy of the policy entitled, "Falling Stars Program". Page 13 of the packet entitled, "Steps to Follow When a Fall Occurs" read in part, "7. Establish new interventions and place them on the care plan. 8.	F 657		

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F 657	Continued From page 73 Implement interventions on care plan." On 11/16/23 at 5:25 PM the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and this issue was discussed. No further information was provided to the survey team prior to the exit conference. 3. For Resident #33, the facility staff failed to revise the comprehensive person-centered care plan to reflect the resident was at risk for elopement and a Wander Guard monitor was applied. The resident's Admission Record listed their diagnoses to included, but were not limited to multiple sclerosis, dementia, Alzheimer's disease, Parkinson's disease with dyskinesia, and type 2 diabetes mellitus. On the quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 10/11/23, the resident scored a 10 out of 15 on the brief interview for mental status. Section P (Restraints and Alarms) read the resident had a wander/elopement alarm daily. On 11/15/23 at 9:38 a.m. this surveyor, along with LPN #8, observed Resident #33 who was wearing a Wander Guard on his right ankle.	F 657		

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F 657	Continued From page 74 This surveyor reviewed Resident #33's comprehensive person-centered care plan and was unable to locate documentation of an elopement risk or Wander Guard device. On 11/16/23 at 8:48 a.m., this surveyor and the chief nursing officer (CNO) spoke with the facility's MDS Coordinator regarding Resident #33's elopement risk and Wander Guard not found on the comprehensive person-centered care plan. The MDS Coordinator provided a list of provider orders for the resident to have a Wander Guard in previous years; 2021, 2022, and 2023. The MDS Coordinator and CNO indicated the elopement risk focus area had been resolved and acknowledged the focus area for elopement risk had not been revised to include it as a current focus area. On 11/16/23, Resident #33's comprehensive person-centered care plan was revised to indicate the resident had a focus area of risk of elopement related to wandering initiated on 11/16/23. This concern was discussed with the administrator, CNO, and regional vice president of operations during an end of day meeting on 11/16/23. No further information was provided prior to the exit conference.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		12/27/23

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F 658	Continued From page 75 by: Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to follow standards of professional practice for 2 of 22 residents, Resident's #242 and #24. The findings included: 1. For Resident #242, the facility nursing staff documented they had administered the medication Isosorbide when this medication had never been delivered to the facility from the pharmacy. This medication was not available in the facility STAT box. Resident #242's diagnoses included hypertension, congestive heart failure, and chronic kidney disease. There was no completed minimum data set (MDS) assessment for this Resident. Resident #242 was alert and orientated to self. Resident #242's clinical record included an order for the medication Isosorbide Mononitrate 10 mg 1 tablet three times a day for hypertension. The order date was documented as 11/08/23. A review of Resident #242's medication administration record (MAR) revealed that the nursing staff had documented they had administered this medication on 11/09/23 at 8:00 a.m. and 2:00 p.m., 11/10/23 at 8:00 a.m. and 2:00 p.m., 11/11/23 at 8:00 a.m., 2:00 p.m. and 8:00 p.m., 11/12/23 at 8:00 a.m. and 2:00 p.m., and again on 11/13/23 at 8:00 a.m. 2:00 p.m. and 8:00 p.m.	F 658	F658 1) Resident #242 Isosorbide medication order clarified on 11/15/2023 by licensed nurse and received by pharmacy on 11/15/2023. Resident discharged to community on 11/29/2023. Resident #24 assessed by Geripsych MD on 11/07/2023 with no change in neuro assessment noted. DON/Designee will complete a MAR to Cart audit on current residents with Isosorbide by 12/27/23 to validate medication available as documented. DON/Designee reviewed subsequent neurocheck completion as indicated on 11/4/23 with no negative findings. 2) DON/Designee will re-educate licensed nurses on Professional Standards and accuracy of documentation by 12/27/23. 3) The DON/Designee will monitor 5 residents MAR and assessment documentation for accuracy and meeting professional standards weekly times 4 weeks. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 4) AOC: 12/27/23	

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F 658	Continued From page 76	F 658		

The facility nursing staff had documented a 7 for 11/08/23 at 2:00 p.m. and 8:00 p.m., a 3 on 11/09/23 and 11/10/23 at 8:00 p.m., and a 7 on 11/12/23 at 8:00 p.m. Per the preprinted code on the MAR a 7=other/see nurses note and a 3=hold/see nurses note.

A review of the progress notes indicated the nursing staff had documented the medication was on hold/awaiting delivery and/or on order from the pharmacy.

The clinical record included a note from the pharmacy dated 11/08/23 that read Isosorbide Mononitrate oral tablet 10 mg give 1 tablet by mouth three times a day for hypertension. The frequency of 3 times per day exceeds the usual frequency of 2 times per day.

On 11/14/23 at 8:45 a.m., Licensed Practical Nurse (LPN) #7 and the surveyor checked the medication cart for this medication. This medication was not located on the medication cart. LPN #7 stated they would have to order the medication.

On 11/14/23 at 9:50 a.m., during an interview with Pharmacy Technician #1 this staff stated this medication had not been sent to the facility and the medication order needed to be clarified.

On 11/14/23 at 10:00 a.m., during an interview with Resident #242 this resident stated they were unaware if they got their medication, they got a cup full.

On 11/15/23 at 10:50 a.m., LPN #7 stated they had not clarified the medication order and they needed to do that. When asked how they

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F 658	Continued From page 77 administered this medication if it was not available, they stated you can't administer it if you ain't got it. On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator, Regional Vice President of Operations, and Chief Nursing Officer the issue with the medication was reviewed. On 11/16/23 at 12:25 p.m., the Administrator provided the survey team with a copy of a policy titled, "Medication Administration General Guidelines." This policy was dated 01/23 and read in part, "...If two consecutive doses of a vital medication are withheld or refused, the physician is notified..." No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #24, the facility staff failed to complete neurological assessments following a fall on 11/03/23 in which the resident hit their head. Resident #24's diagnosis list indicated diagnoses,	F 658		

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F 658	Continued From page 78	F 658		

which included, but not limited to Iliotibial Band Syndrome of the Right Leg, Dementia, Major Depressive Disorder, Mood Disorder, Generalized Anxiety Disorder, Nightmare Disorder, Parkinson's Disease, Unsteadiness on Feet, and Muscle Weakness.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/15/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #24 was coded as requiring limited assistance with transfers, dressing, and personal hygiene. The resident was coded as having one fall with no injury since the prior MDS assessment.

On 11/14/23 at 10:20 AM, surveyor spoke with Resident #24 who stated they have falls because they reach in the floor for things. The resident stated "a week or two ago" they fell and landed on their head.

Resident #24's clinical record included a nursing progress note dated 11/03/23 3:32 PM which read in part "resident fell from wheelchair ...some redness on the forehead ..." Surveyor reviewed the Resident's "Neurological Assessment Flowsheet" initiated on 11/03/23 at 1:25 PM. The flowsheet was blank for level of consciousness, pupil response, hand grasps, motor function extremities, pain response, and staff signature for the following times: 11/03/23 1:25 PM, 1:40 PM, 1:55 PM, 2:10 PM, 3:10 PM, 4:10 PM, 5:10 PM, and 6:10 PM with only vital signs documented.

Surveyor requested and received the facility policy titled "Neurological Assessment" which

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F 658	Continued From page 79 read in part "Resident with a suspected head injury will have neurological signs monitored and recorded. Neurological observations are the responsibility of licensed nurses ...Document neurological checks on the Neurologic Assessment Sheet ...Level of Consciousness ...Pupil Response ...Motor Function ...Pain Response ...Vital Signs ...Observations ..." On 11/15/23 at 9:45 AM, surveyor spoke with the Interim Director of Nursing (DON) regarding Resident #24's neurological checks. The DON stated they did not know why the neuro checks were not completed. On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of the incomplete neurological checks following Resident #24's fall on 11/03/23. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		12/27/23

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F 684	Continued From page 80 by: Based on observation, staff interview, clinical record review, facility document review, the facility staff failed to follow physician's orders for 3 of 22 residents, Resident #51, Resident #86, and Resident #242. The findings included: 1. For Resident #51 the facility staff failed to administer the medication Zoloft. Zoloft is a medication used to treat depression. Resident #51's face sheet listed diagnoses which included but not limited to Alzheimer's disease, anxiety, depression, and dementia. Resident #51's most recent minimum data set with an assessment reference date of 10/18/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #51's comprehensive care plan was reviewed and contained a care plan for "I am taking an antidepressant medication." Interventions for this care plan include "Medication as ordered by the physician." Resident #51's clinical record was reviewed and contained a physician's order summary which read in part, "Zoloft Tablet 50 mg (Sertraline HCl). Give 1 tablet by mouth one time a day for major depressive disorder, recurrent, unspecified." On 11/14/23 at 7:50 am, surveyor observed licensed practical nurse (LPN) #6 during a medication pass and pour. LPN #6 prepared	F 684	F684 1) Resident #51 zoloft medication received from pharmacy on 11/15/2023. Resident #86 identified wound resolved 11/22/2023. Resident #242 Isosorbide and plavix medication order clarified on 11/15/2023 and received by pharmacy on 11/15/2023. Resident discharged to community on 11/29/2023. 2) The DON/Designee reviewed current resident's Zoloft, isosorbide, Plavix and wound care orders by the physician for accuracy and completion by 12/27/23. 3) The DON/Designee re-educated licensed nurses on Quality of Care related to following physician's orders by 12/27/23. 4) The DON/Designee will review 5 resident's new orders for accuracy of following physician's orders per week times 4 weeks. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 684	Continued From page 81 Resident #51's medications but stated that the Zoloft was not available in the medication cart. LPN #6 stated, "I'll probably have to call the pharmacy about the Zoloft." Surveyor asked LPN #6 to let them know when the had the Zoloft for administration. Surveyor was never informed that the Zoloft was available or administered. Surveyor requested and was provided with the process for unavailable medications which read in part, "Medication not Available-Nurse's Process. 1. Look in backup medication. 2. Look in the EDK (emergency drug kit) box for the medication. 3. Notify the physician/practitioner that the medication is not available-request an order to give when the medication arrives from the pharmacy or to skip that dose. 4. Enter a onetime order for the medication to be given upon delivery or to skip that dose. a. Note the time the medication is due to ensure not given too close." Surveyor requested and was provided with a list of medications available in the back medication and/or EDK. This list contained the medication sertraline 25 mg, four tablets. The concern of not administering Resident #51's Zoloft per the physician's order was discussed with the administrator, chief nursing officer, and regional vice president of operations on 11/16/23 at 5 pm. No further information was provided prior to exit. 2. For Resident #86, the facility staff failed to treat an abdominal surgical wound as directed by the wound specialist from 11/03/23 through	F 684		

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F 684	Continued From page 82 11/10/23. Resident #86's diagnosis list indicated diagnoses, which included, but not limited to Pressure Ulcer of Right Buttocks, Open Wound of Abdominal Wall, Ventral Hernia with Obstruction, Type 2 Diabetes Mellitus, and Muscle Weakness. According to Resident #86's demographic face sheet, the resident was admitted to the facility on 11/02/23. An "Admission Data Collection Form" dated 11/02/23 documented the resident as being alert and independent in decisions regarding tasks of daily living. On 11/13/23 at 5:17 PM, surveyor spoke with Resident #86 who stated they had a surgical wound on their stomach and the dressing had not been changed every day. The resident's current physician's orders included an active order dated 11/10/23 to clean area to surgical wound of abdomen with normal saline, apply sure prep to peri-wound, then apply Collagen powder to wound bed and cover with bordered gauze dressing daily. A previous order dated 10/27/23 (with previous admission) for zinc oxide paste dressing to abdomen topically as needed for dry skin scabs remained active with admission on 11/02/23 and was discontinued on 11/10/23. According to the November 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR), the zinc had not been applied since admission on 11/02/23. The first documented treatment to Resident #86's abdominal surgical wound following admission on 11/02/23 occurred on 11/11/23. Resident #86 was assessed by the wound specialist on 11/03/23, the progress note	F 684		

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documented a post-surgical wound to the abdomen measuring 6.4 x 2.9 x 0.1 cm with light serous exudate and 50% granulation tissue. Treatment plan was documented as Collagen powder with a gauze island with border dressing and skin prep to the peri wound once daily for 30 days.

Resident #86 was reassessed by the wound specialist on 11/08/23, the progress note documented the abdominal surgical wound as measuring 0.8 x 0.5 x 0.1 cm with light serous exudate and 50% granulation tissue. The treatment plan remained as Collagen powder with a gauze island with border dressing and skin prep to the peri wound once daily for 25 days.

On 11/15/23 at 11:30 AM, surveyor spoke with the Interim Director of Nursing (DON) regarding reason for the resident's surgical wound treatment not being started until 11/11/23, the DON stated they would look into it. However, no additional information was provided.

On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of Resident #86 not receiving treatment as directed by the wound specialist.

No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.

3. For Resident #242, the facility nursing staff failed to administer the medications Plavix and Isosorbide as ordered by the provider.

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F 684	Continued From page 84	F 684		

Resident #242's diagnoses included, but were not limited to, hypertension, chronic kidney disease, anxiety, and acute pulmonary disease.

There was no completed minimum data set (MDS) assessment for this Resident. Resident #242 was alert and orientated to self.

Resident #242's clinical record included provider orders for Plavix 75 mg 1 tablet by mouth at bedtime and Isosorbide Mononitrate 10 mg 1 tablet three times a day for hypertension. The order date for both medications was documented as 11/08/23.

For the medication Plavix-A review of the medication administration records (MARs) revealed that the nursing staff had documented a 7 for the administration of the Plavix on 11/08/23 and 11/12/23. Per the preprinted code on these MAR's a 7=Other/see nurses notes.

A review of the nursing notes revealed that the facility nursing staff had documented on 11/08/23 new admission awaiting medications from pharmacy. On 11/12/23 the nursing staff documented medication not available on order from pharmacy. A review of the stat box list revealed that this medication was available in the STAT box for administration.

For the medication Isosorbide-A review of the clinical record revealed that the nursing staff had documented they had administered this medication on 11/09/23 at 8:00 a.m. and 2:00 p.m., 11/10/23 at 8:00 a.m. and 2:00 p.m., 11/11/23 at 8:00 a.m., 2:00 p.m. and 8:00 p.m., 11/12/23 at 8:00 a.m. and 2:00 p.m., and again on 11/13/23 at 8:00 a.m. 2:00 p.m. and 8:00 p.m.

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F 684	Continued From page 85 The facility nursing staff had documented a 7 for 11/08/23 at 2:00 p.m. and 8:00 p.m., a 3 on 11/09/23 and 11/10/23 at 8:00 p.m., and a 7 on 11/12/23 at 8:00 p.m. Per the preprinted code on the MAR a 7=other/see nurses note and a 3=hold/see nurses note. A review of the progress notes indicated the nursing staff had documented the medication was on hold/awaiting delivery and/or on order from the pharmacy. The clinical record included a note from the pharmacy dated 11/08/23 that read Isosorbide Mononitrate oral tablet 10 mg give 1 tablet by mouth three times a day for hypertension. The frequency of 3 times per day exceeds the usual frequency of 2 times per day. On 11/14/23 at 8:45 a.m., Licensed Practical Nurse (LPN) #7 and the surveyor checked the medication cart for the Isosorbide. This medication was not located on the medication cart. LPN #7 stated they would have to order the medication. On 11/14/23 at 9:50 a.m., during an interview with Pharmacy Technician #1 this staff stated this medication had not been sent to the facility and the order needed to be clarified. On 11/14/23 at 10:00 a.m., during an interview with Resident #242 this resident stated they were unaware if they got their medication, they got a cup full. On 11/15/23 at 10:50 a.m., during an interview with LPN #7 this staff stated they had not clarified	F 684		

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F 684	Continued From page 86 the medication order and they needed to do that. When asked how they administered this medication if it was not available, they stated you can't administer it if you ain't got it. On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator, Regional Vice President of Operations, and Chief Nursing Officer the issue with the medications was reviewed. On 11/16/23 at 12:25 p.m., the Administrator provided the survey team with a copy of a policy titled, "Medication Administration General Guidelines." This policy was dated 01/23 and read in part, "...If two consecutive doses of a vital medication are withheld or refused, the physician is notified..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		12/27/23

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F 686	Continued From page 87 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a resident with pressure ulcers receives necessary treatment and services to promote healing for 1 of 22 residents in the survey sample, Resident #86. The findings included: For Resident #86, the facility staff failed to treat a stage 3 pressure ulcer to the sacrum as directed by the wound specialist from 11/03/23 through 11/10/23. Resident #86's diagnosis list indicated diagnoses, which included, but not limited to Pressure Ulcer of Right Buttocks, Open Wound of Abdominal Wall, Ventral Hernia with Obstruction, Type 2 Diabetes Mellitus, and Muscle Weakness. According to Resident #86's demographic face sheet, the resident was admitted to the facility on 11/02/23. An "Admission Data Collection Form" dated 11/02/23 documented the resident as being alert and independent in decisions regarding tasks of daily living. On 11/13/23 at 5:17 PM, surveyor spoke with Resident #86 who stated the dressing to their bottom was not being changed every day. The resident's current physician's orders included an active order dated 11/10/23 to clean area to medial sacrum with normal saline, apply sure prep to peri-wound, then apply collagen powder to wound bed and cover with bordered gauze	F 686	F686 1) Resident #86 identified wound resolved on 11/22/2023. 2) The center identified current resident's with pressure ulcers to be at risk. The DON/Designee reviewed the treatment records of current residents with pressure ulcers to validate the resident received treatments and services to promote wound healing with no negative findings by 12/27/23. 3) The DON/Designee re-educated the licensed nurses regarding providing necessary treatments and services to promote wound healing as indicated by 12/27/23. 4) The DON/Designee will review 3 resident treatment orders per week x 4 weeks to validate necessary treatments and services for wound healing are completed as indicated. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 686	Continued From page 88 dressing daily. Resident #86 was assessed by the wound specialist on 11/03/23, the progress note documented a stage 3 pressure wound of the medial sacrum measuring 0.6 x 0.3 x 0.1 cm with light serous exudate and 100% granulation tissue. The dressing treatment plan was collagen powder, gauze island with border, and skin prep to peri-wound once daily for 30 days. The resident was reassessed by the wound specialist on 11/08/23, the progress note described the area as 0.4 x 0.4 x 0.1 cm with light serous exudate and 100% granulation tissue. The treatment plan remained as collagen powder, gauze island with border, and skin prep to peri-wound once daily for 25 days. Surveyor reviewed Resident #86's clinical record and was unable to locate an order for treatment to the sacral pressure ulcer from admission on 11/02/23 through 11/10/23. According to the resident's November 2023 Treatment Administration Record (TAR), treatment to the sacral pressure wound began on 11/11/23. On 11/15/23 at 11:30 AM, surveyor spoke with the Interim Director of Nursing (DON) regarding explanation for the resident not receiving treatment to the sacral pressure wound from 11/02/23 through 11/10/23. The DON stated they would look into it. However, no additional information was provided. Surveyor requested and received the facility policy titled "Skin Program" which read in part " ...Resident(s) with wounds will have appropriate treatment ..."	F 686		

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F 686	Continued From page 89 On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Regional Vice President of Operations, and the Chief Nursing Officer and discussed the concern of Resident #86 not receiving treatment as directed by the wound specialist. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 686		
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure each resident received assistance devices to prevent accidents for 1 of 22 residents in the survey sample, Resident #24. The findings included: For Resident #24, the facility staff failed to ensure placement of Dycem non-slip material in the resident's wheelchair seat as indicated on the resident's comprehensive person-centered care plan.	F 689	F730 1) Current eligible CNAs performance evaluations will be completed by the appropriate supervisor on or before 12/27/23. Current CNAs will complete 12 hour education/in-services on or before 12/27/23. 2) The Administrator/Designee reviewed current CNA records to determine due dates for completion of 12 hour education/in-services and performance evaluations and notified current CNAs for timely completion. 3) The Administrator/Designee will	12/27/23

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F 689	Continued From page 90 Resident #24's diagnosis list indicated diagnoses, which included, but not limited to Iliotibial Band Syndrome of the Right Leg, Dementia, Major Depressive Disorder, Mood Disorder, Generalized Anxiety Disorder, Nightmare Disorder, Parkinson's Disease, Unsteadiness on Feet, and Muscle Weakness. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/15/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #24 was coded as requiring limited assistance with transfers, dressing, and personal hygiene. The resident was coded as having one fall with no injury since the prior MDS assessment. Resident #24's current comprehensive person-centered care plan included a focus area stating in part "[Name omitted] is at risk for fall-related injury due to: Parkinson's, Use of medication, History of falls. Resident continue [sic] to try and perform tasks without asking staff for assistance. Attempts to perform task without changing positions. Resident cognition fluctuates at times, [he/she] has a poor safety awareness at times. [He/She] is also noted to have IT [Iliotibial] band syndrome on right leg. Resident with hx [history] of seizure like episode and become [sic] unresponsive and slides out of w/c [wheelchair]. Resident at times states [he/she] is having 'fainting spells.' Resident often attempts to pick things up off floor and slides out of wheelchair to floor ..." The resident's fall risk care plan included an intervention dated 4/12/23 for Dycem to wheelchair seat.	F 689	re-educate current CNAs on completion of 12 hour education/in-services and Relias program information on or before 12/27/23. Nursing supervisors will be re-educated by the Administrator/Designee on timely completion of CNA performance evaluations on or before 12/27/23. 4) The Administrator/Designee will review 3 CNA employee records per week times 4 weeks to validate timely completion of required education/in-services and performance evaluation completion. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 689	Continued From page 91 On 11/14/23 at 10:20 AM, surveyor spoke with Resident #24 who stated they have falls because they reach in the floor for things. On 11/15/23 at 11:15 AM, certified nursing assistant (CNA) #7 and licensed practical nurse (LPN) #6 assisted Resident #24 to stand up from their wheelchair, there was no Dycem present in the wheelchair seat. CNA #7 verified the absence of the Dycem non-slip material in the seat. CNA #7 and LPN #6 assisted the resident back to the wheelchair. Surveyor requested and received the facility policy titled "Falls Prevention Program" which read in part " ...The assigned C.N.A. on all shifts needs to be held accountable to ensure that the Care Plan to eliminate falls is being implemented ..." On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of Resident #24 not having Dycem in use as indicated on the care plan. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 689		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	F 730		12/27/23

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F 730	Continued From page 92 reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to complete reviews of nurse aide's at least every 12 months and failed to provide in-service education based on the outcome of these reviews. The findings included: The facility administrative staff failed to complete performance reviews of nurse aides at least every 12 months and failed to provide regular in-service education based on the outcomes of reviews/evaluations. During the task sufficient and competent nurse staffing the surveyor requested information regarding nurse aide reviews/evaluations and in-service training. On 11/14/23 at 4:30 p.m., during an end of the day meeting with the Administrator, Regional Vice President of Operations (RVPO), and Chief Nursing Officer the RVPO stated they should be doing yearly evaluations on staff. On 11/15/23 at 8:26 a.m., during an interview with the Administrator this staff stated performance evaluations have not been completed and the supervisor was the person who would be responsible for completing the reviews. On 11/15/23 at 9:10 a.m., Certified Nursing Assistant (C.N.A.) #3 stated they had been employed at the facility over a year, they received training through a computer based program, the	F 730	F689 1) DON/Designee reviewed resident #24 fall interventions and validated current fall intervention of dycem in wheelchair is appropriate and present on 11/15/23. 2) The center identified current residents with dycem in wheelchair as a fall intervention at risk. The DON/Designee reviewed current resident's with dycem in wheelchair as a fall intervention, validated it was present on or before 12/27/2023. 3) The DON/Designee re-educated licensed nurses and IDT regarding fall intervention guidance on or before 12/27/2023. 4) The DON/Designee will monitor 3 resident fall care plan interventions and validate presence of interventions weekly x 4 weeks. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/2023	

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F 730	Continued From page 93 training was appropriate, and they had not had a performance evaluation/review. On 11/15/23 at 8:26 a.m., the Administrator stated the performance evaluations had not been completed. On 11/16/23, the Administrator provided the surveyor with a copy of their policy titled Performance Evaluations with an effective date 11/28/17. This policy read in part, "The Performance evaluation provides a formal vehicle for the supervisor and the employee to discuss the employers overall work performance and developmental areas as it relates to the employee's job description..." The Administrator also provided the surveyor with a copy of a blank document titled, Annual Performance Review Form. This document would score the employee on their performance and job knowledge. There was an area where the administrative staff could document areas of improvement, developmental plans and/or upcoming objectives. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		12/27/23

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F 755	Continued From page 94 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and during a medication pass and pour the facility staff failed to ensure medications were available for administration of 2 of 22 residents, Resident #3 and Resident #294. The findings included: 1. For Resident #3 the facility staff failed to ensure the medication Vitamin D was available for administration.	F 755	F755 1) Resident #3 Vitamin D medication order clarified and medication received 11/15/2023. Resident #294 Merrem medication completed with no new orders regarding treatment for associated diagnosis. 2) The center identified current residents with orders for Vitamin D and Merrem to be at risk. The DON/Designee will complete a MAR to cart audit on for	

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F 755	Continued From page 95 Resident #3's face sheet listed diagnoses which included but not limited to Vitamin D deficiency, unspecified. Resident #3's most recent minimum data set with an assessment reference date of 10/24/23 assigned the resident a brief interview for mental status score of 5 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively intact. Surveyor observed licensed practical nurse (LPN) #6 during a medication pass and pour on 11/14/23 at 7:55 am. LPN #6 prepared Resident #3's medications but stated that the resident's Vitamin D was not available in the medication cart, and they would have to get it from the medication room. LPN #6 stated that Vitamin D 400 iu and Vitamin D 500 iu was in the cart, but Resident #6 takes Vitamin D 4000 iu. Surveyor asked LPN #6 to let them know when they had the medication available for administration. Surveyor was never informed that the Vitamin D was available or administered. Surveyor reconciled Resident #3's medications with the clinical record. Resident #3's clinical record contained a physician's order summary which read in part, "Vitamin D Tablet (cholecalciferol). Give 4000 iu by mouth one time a day for supplementation." Surveyor requested and was provided with the process for unavailable medications which read in part, "Medication not Available-Nurse's Process. 1. Look in backup medication. 2. Look in the EDK (emergency drug kit) box for the medication. 3. Notify the physician/practitioner that the medication is not available-request an order to	F 755	Vitamin D and Merrem or before 12/27/23 to verify medication availability. 3) The DON/Designee will re-educate licensed nurses on medication availability and guidance on next steps when medication is not available on or before 12/27/23. 4) The DON/Designee will monitor 5 resident MARs per week times 4 weeks to validate Medication availability. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 755	Continued From page 96	F 755		

give when the medication arrives from the pharmacy or to skip that dose. 4. Enter a onetime order for the medication to be given upon delivery or to skip that dose. a. Note the time the medication is due to ensure not given too close."

Surveyor requested and was provided with a list of medications available in the backup medication and/or EDK. Vitamin D 4000 iu was not listed as available in the backup medication and/or EDK.

The concern of not having Resident #6's medication available for administration was discussed with the administrator, chief nursing officer, and regional vice president of operations on 11/16/23 at 5 pm.

No further information was provided prior to exit.

2. For Resident #294 the facility staff failed to ensure the medication, Merrem was available for administration resulting in the resident missing seven scheduled doses. Merrem is an antibiotic used to treat infections.

Resident #294's face sheet listed diagnoses which included but not limited to sepsis and malignant neoplasm of pancreatic duct.

Resident #294's minimum data set was not yet completed; however, Resident # 294 was alert and oriented to person, place, time, and situation.

Resident #294's clinical record was reviewed and contained a physician's order summary which read in part, "Merrem Intravenous Solution Reconstituted 500 mg (Meropenem). Use 2000 mg intravenously every 8 hours for sepsis for 5

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F 755	Continued From page 97 days." Resident #294's electronic medication administration record for the month of November 2023 was reviewed and contained an entry which read in part, "Merrem Intravenous Solution Reconstituted 500 mg (Meropenem). Use 2000 mg intravenously every 8 hours for sepsis for 5 days." This entry was coded "7" on 11/03/23 and 11/04/23, and coded "3" at 12:00 am on 11/05/23. Chart code "7" is equivalent to "Other/See Nurse Notes." Chart code "3" is equivalent to "Hold/See Nurse Notes." Resident #294's nurse's progress notes were reviewed and contained notes which read in part, "Effective Date: 11/02/2023 16:19 Note Text: new admission, meds not available from pharmacy.", Effective Date: 11/02/2023 23:56 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. new admission, meds not available from pharmacy.", "Effective Date: 11/03/2023 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. not available from pharmacy.", "Effective Date: 11/03/2023 16:54 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. waiting for med from pharmacy.", "Effective Date: 11/03/2023 23:04 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. awaiting delivery from pharmacy.", "Effective Date: 11/04/2023 08:49 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis	F 755		

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F 755	Continued From page 98	F 755		

for 5 days. waiting for pharmacy to send mes (message)", "Effective Date: 11/04/2023 16:01 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. waiting on med from pharmacy", and "Effective Date: 11/05/2023 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. Awaiting delivery."

Surveyor requested and was provided with the process for unavailable medications which read in part, "Medication not Available-Nurse's Process. 1. Look in backup medication. 2. Look in the EDK (emergency drug kit) box for the medication. 3. Notify the physician/practitioner that the medication is not available-request an order to give when the medication arrives from the pharmacy or to skip that dose. 4. Enter a onetime order for the medication to be given upon delivery or to skip that dose. a. Note the time the medication is due to ensure not given too close."

Surveyor requested and was provided with a list of medications available in the backup medication and/or EDK. Mererm intravenous solution was not listed as available in the backup medication and/or EDK.

During a meeting with the administrator, chief nursing officer, and regional vice-president of operations on 11/15/23 at 3:30 pm, surveyor asked if the facility had a back-up pharmacy, and what the procedure was to obtain needed medications from them. Regional vice president of operations stated if they need medications, they would contact the pharmacy, and the pharmacy would take care of it. On 11/16/23,

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F 755	Continued From page 99 surveyor was provided with an email from pharmacy director of accounts, which read in part, "For a backup pharmacy what your team would need to do is: Call the main pharmacy number (unless we've already reached out to you regarding a stock issue). Let us know you need it prior to our next delivery and want it from a backup pharmacy. We will contact local pharmacies in your area to locate the product, transfer an order over, and arrange for pickup and delivery to your building. Once you let us know you need it from a backup pharmacy, we take care of the rest." The concern of not ensuring Resident #294's medication was available for administration was discussed with the administrator, chief nursing officer, and regional vice-president of operations on 11/16/23 at 5 pm. No further information was provided prior to exit.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		12/27/23

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F 756	Continued From page 100 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to act upon drug regimen review recommendations for 1 of 22 residents in the survey sample, Resident #24. The findings included: For Resident #24, the facility staff failed to carry out a physician approved drug regimen review recommendation for a movement test, such as AIMS or DISCUS, to be performed at least every six months.	F 756	F756 1) Resident #24 AIMS was completed per the 07/25/2023 pharmacy recommendation on 07/28/2023 and uploaded to the document section of PCC on 07/31/2023. Off cycle AIMS was completed on 11/30/2023 by licensed nurse. 2) The DON/Designee reviewed pharmacy recommendations and completed orders per the physician orders on or before 12/27/23. 3) The DON/ Designee re-educated the	

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F 756	Continued From page 101 Resident #24's diagnosis list indicated diagnoses, which included, but not limited to Iliotibial Band Syndrome of the Right Leg, Dementia, Major Depressive Disorder, Mood Disorder, Generalized Anxiety Disorder, Nightmare Disorder, Parkinson's Disease, Unsteadiness on Feet, and Muscle Weakness. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/15/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #24 was coded as requiring limited assistance with transfers, dressing, and personal hygiene. The resident was coded as having one fall with no injury since the prior MDS assessment. Surveyor reviewed Resident #24's pharmacy drug regimen review dated 7/25/23 which read in part " ...Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. This resident continues risperidone. The last AIMS/DISCUS test located in the chart was dated March 2023 ..." The physician checked the box indicating agreement with the recommendation, signed and dated the form on 7/27/23. On 11/15/23, surveyor reviewed Resident #24's clinical record and was unable to locate an AIMS or DISCUS test following the 7/27/23 physician signed drug regimen review. The most recent AIMS test in the resident's clinical record was dated 3/31/23.	F 756	interdisciplinary team (IDT) regarding pharmacy recommendation process and timely completion of accepted recommendations on or before 12/27/23. 4) The DON/Designee will monitor 5 resident records per week times 4 weeks for completion of pharmacy recommendations. Findings will be reviewed weekly in QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 756	Continued From page 102 On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of staff failing to complete an AIMS or DISCUS test as agreed upon by the physician. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		12/27/23

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F 758	Continued From page 103 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure PRN (as needed) orders for psychotropic drugs were limited to 14 days for 1 of 22 residents in the survey sample, Resident #24. The findings included: For Resident #24, the facility staff failed to ensure the order for the medication Vistaril included a duration limited to 14 days. Vistaril is an antihistamine drug which may be used to relieve anxiety and tension. Resident #24's diagnosis list indicated diagnoses,	F 758	F758 1) Resident #24 Vistaril order was assessed by prescribing Geripsych physician on 11/07/2023 with recommendation to continue medication regimen for treatment of diagnosis of anxiety including continued use of prn Vistaril. Resident assessed by prescribing Geripsych physician on 11/29/2023 with recommendation to continue medication regimen for treatment of diagnosis of anxiety including continue prn use of Vistaril, the MD was notified of the recommendation and corrections will be	

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F 758	Continued From page 104 which included, but not limited to Iliotibial Band Syndrome of the Right Leg, Dementia, Major Depressive Disorder, Mood Disorder, Generalized Anxiety Disorder, Nightmare Disorder, Parkinson's Disease, Unsteadiness on Feet, and Muscle Weakness. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/15/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #24's clinical record included a current physician's order dated 10/31/23 for Vistaril 50 mg three times a day as needed for increased anxiety. A corresponding nursing progress note dated 10/31/23 8:00 PM read in part "Resident complaining of increased anxiety and stated it had gotten worse the last two days. [name omitted], MD notified and gave orders for Vistaril 50 mg PRN [as needed] TID [three times a day] ..." According to Resident #24's clinical record as of 11/14/23, the resident had received the PRN Vistaril on nine (9) separate occasions since receiving the order on 10/31/23. Surveyor reviewed the resident's clinical record and was unable to locate documentation of the prescribing provider's rationale indicating the duration for administration of Vistaril. On 11/16/23 at 4:59 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of Resident #24 receiving	F 758	made per order. Resident original Vistaril prescription dated 9/9/2015 with multiple unsuccessful GDR attempts. Geripsych physician expert recommendation to continue medication and reassess with visits and as needed. 2) DON/Designee reviewed current resident's prn psychotropic medication regimen for 14 day stop date with no negative findings. 3) The DON/Designee re-educated current licensed nurses and provided information to the physicians/mid-levels with prescribing authority in the center regarding prn psychotropic medications on or before 12/27/23. 4) The DON/Designee will review new orders for prn psychotropic medication weekly times 4 weeks then monthly x 2 for 14 day stop date and/or physician documented rationale for extended order timeframe. Findings to be reviewed during monthly QAA meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 758	Continued From page 105 PRN Vistaril without a specified duration. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and during a medication pass and pour the facility staff failed to ensure a medication error rate of less than 5%. There were 2 errors in 30 opportunities for a medication error rate of 6.67%. These errors affected Resident #3 and Resident #12. The findings included: On 11/14/23 at 7:50 am, surveyor observed licensed practical nurse (LPN) #6 during a medication pass and pour. LPN #6 prepared Resident #51's medications but stated that the Zoloft was not available in the medication cart. LPN #6 stated, "I'll probably have to call the pharmacy about the Zoloft." Surveyor asked LPN #6 to let them know when the had the Zoloft for administration. Surveyor was never informed that the Zoloft was available or administered. Surveyor reconciled Resident #51's medications with the clinical record. Resident #51's clinical	F 759	F759 1) Resident #51 Zoloft medication validated for administration as ordered. Resident #3 Vitamin D medication validated for administration as ordered. Validated by the DON/Designee on 11/15/23. 2) The center identified current resident's with Zoloft and Vitamin D orders to be at risk. The DON/Designee completed a MAR to cart audit validating Zoloft and Vitamin D medication availability for administration as ordered on or before 12/27/23. 3) The DON\Designee re-educated licensed nurses on medication not available guidance on or before 12/27/2023. 4) The DON/Designee will audit 5 resident MARs per week x 4 weeks to validate medication availability. Findings will be reviewed during QAPI meeting.	12/27/23

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F 759	Continued From page 106 record contained a physician's order summary which read in part, "Zoloft Tablet 50 mg (Sertraline HCl). Give 1 tablet by mouth one time a day for major depressive disorder, recurrent, unspecified." Surveyor observed licensed practical nurse (LPN) #6 during a medication pass and pour on 11/14/23 at 7:55 am. LPN #6 prepared Resident #3's medications but stated that the resident's Vitamin D was not available in the medication cart, and they would have to get it from the medication room. LPN #6 stated that Vitamin D 400 iu and Vitamin D 500 iu was in the cart, but Resident #6 takes Vitamin D 4000 iu. Surveyor asked LPN #6 to let them know when they had the medication available for administration. Surveyor was never informed that the Vitamin D was available or administered. Surveyor reconciled Resident #3's medications with the clinical record. Resident #3's clinical record contained a physician's order summary which read in part, "Vitamin D Tablet (cholecalciferol). Give 4000 iu by mouth one time a day for supplementation." The concern of not ensuring a medication error rate of less than 5% was discussed with the administrator, chief nursing officer, and regional vice president of operations on 11/16/23 at 5 pm. No further information was provided prior to exit.	F 759	Additional interventions to be initiated as needed. 5) AOC: 12/27/2023	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		12/27/23

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F 760	Continued From page 107 medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure 4 of 22 residents were free of significant medication errors, Residents #242, #294, #48, and #34. The findings included: 1. For Resident #242, the facility staff failed to administer Plavix as ordered by the provider. Plavix prevents platelets in your blood from sticking together to form an unwanted blood clot that could block an artery. Resident #242's diagnoses included, but were not limited to, chronic kidney disease, dementia, anxiety, and acute pulmonary disease. There was no completed minimum data set (MDS) assessment for this Resident. Resident #242 was alert and orientated to self. Resident #242's clinical record included a provider order dated 11/08/23 for the medication Plavix 75 mg 1 tablet by mouth at bedtime. A review of the medication administration records (MAR's) revealed that the nursing staff had documented a 7 for the administration of the Plavix on 11/08/23 and 11/12/23. Per the preprinted code on these MAR's a 7=0ther/see nurses notes. A review of the nursing notes revealed that the facility nursing staff had documented on 11/08/23	F 760	F760 1) Resident #242 no longer resides in the center. Resident #48 continues on Metoprolol Tartrate with no negative outcome. Resident #294 Merrem medication regimen completed with no negative effects noted. Resident #34 continues on Coreg medication with no negative outcome. Medication review completed on 11/28/23. 2) DON/Designee reviewed current resident's receiving Metoprolol Tartrate, Merrem, Coreg and Plavix orders to validate administration instructions and MAR to Cart audit completed with no negative findings on or before 12/27/23. 3) The DON/Designee re-educated the licensed nurses on the process when medications are not available and medication parameters guidance on or before 12/27/23. 4) The DON/Designee will monitor 5 resident MARs per week times 4 weeks to validate Medication availability and medication parameter guidance. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 760	Continued From page 108 new admission awaiting medications from pharmacy. On 11/12/23 the nursing staff documented medication not available on order from pharmacy. A review of the stat box list revealed that this medication was available in the STAT box for administration. On 11/14/23 at 10:00 a.m., during an interview with Resident #242 this resident stated they were unaware if they got their medication, they got a cup full. On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator, Regional Vice President of Operations, and Chief Nursing Officer the issue with the Plavix not being administered and being available in the stat box was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #294 the facility staff failed to ensure the medication, Merrem was available for administration resulting in the resident missing seven scheduled doses. Merrem is an antibiotic used to treat infections. Resident #294's face sheet listed diagnoses	F 760		

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F 760	Continued From page 109	F 760		

which included but not limited to sepsis and malignant neoplasm of pancreatic duct.

Resident #294's minimum data set was not yet completed; however, Resident # 294 was alert and oriented to person, place, time, and situation.

Resident #294's clinical record was reviewed and contained a physician's order summary which read in part, "Merrem Intravenous Solution Reconstituted 500 mg (Meropenem). Use 2000 mg intravenously every 8 hours for sepsis for 5 days."

Resident #294's electronic medication administration record for the month of November 2023 was reviewed and contained an entry which read in part, "Merrem Intravenous Solution Reconstituted 500 mg (Meropenem). Use 2000 mg intravenously every 8 hours for sepsis for 5 days." This entry was coded "7" on 11/03/23 and 11/04/23, and coded "3" at 12:00 am on 11/05/23. Chart code "7" is equivalent to "Other/See Nurse Notes." Chart code "3" is equivalent to "Hold/See Nurse Notes."

Resident #294's nurse's progress notes were reviewed and contained notes which read in part, "Effective Date: 11/02/2023 16:19 Note Text: new admission, meds not available from pharmacy.", Effective Date: 11/02/2023 23:56 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. new admission, meds not available from pharmacy.", "Effective Date: 11/03/2023 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. not available from

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F 760	Continued From page 110	F 760		

pharmacy.", "Effective Date: 11/03/2023 16:54 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. waiting for med from pharmacy.", "Effective Date: 11/03/2023 23:04 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. awaiting delivery from pharmacy.", "Effective Date: 11/04/2023 08:49 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. waiting for pharmacy to send mes (message)", "Effective Date: 11/04/2023 16:01 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. waiting on med from pharmacy", and "Effective Date: 11/05/2023 Note Text: Merrem Intravenous Solution Reconstituted 500 mg. Use 2000 mg intravenously every 8 hours for sepsis for 5 days. Awaiting delivery."

Surveyor requested and was provided with the process for unavailable medications which read in part, "Medication not Available-Nurse's Process. 1. Look in backup medication. 2. Look in the EDK (emergency drug kit) box for the medication. 3. Notify the physician/practitioner that the medication is not available-request an order to give when the medication arrives from the pharmacy or to skip that dose. 4. Enter a onetime order for the medication to be given upon delivery or to skip that dose. a. Note the time the medication is due to ensure not given too close."

Surveyor requested and was provided with a list of medications available in the backup medication and/or EDK. Merrerm intravenous solution was

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F 760	Continued From page 111 not listed as available in the backup medication and/or EDK. During a meeting with the administrator, chief nursing officer, and regional vice-president of operations on 11/15/23 at 3:30 pm, surveyor asked if the facility had a back-up pharmacy, and what the procedure was to obtain needed medications from them. Regional vice president of operations stated, "If they need medications, they would contact the pharmacy, and the pharmacy would take care of that." On 11/16/23, surveyor was provided with an email from pharmacy director of accounts, which read in part, "For a backup pharmacy what your team would need to do is: Call the main pharmacy number (unless we've already reached out to you regarding a stock issue). Let us know you need it prior to our next delivery and want it from a backup pharmacy. We will contact local pharmacies in your area to locate the product, transfer an order over, and arrange for pickup and delivery to your building. Once you let us know you need it from a backup pharmacy, we take care of the rest." The concern of not ensuring Resident #264 was free of significant medication error was discussed with the administrator, chief nursing officer, and regional vice-president of operations on 11/16/23 at 5 pm. No further information was provided prior to exit.	F 760		

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F 760	Continued From page 112 3. For Resident #48, facility staff failed to administer the antihypertensive medication per administration parameters. Resident #48 was admitted to the facility with diagnoses including essential hypertension, type 2 diabetes mellitus with complications, cerebrovascular disease, major depression, dysphagia, and muscular weakness. On the Minimum Data Set Assessment with Assessment Reference Date 10/10/23, the resident scored 3/15 on the Brief Interview for Mental Status and was assessed with signs of delirium with fluctuating inattention and disorganized thinking. Clinical record review revealed a physician order dated 7/8/2022 for metoprolol tartrate tablet 25 milligrams (mg). Give 25 mg by mouth two times a day related to essential hypertension hold if SBP (systolic blood pressure) <100 or DBP (diastolic blood pressure)<60 or HR (heart rate) <55. The Medication Administration Record (MAR) for November 2023 documented blood pressure and heart rate for each administration time and whether the medication was administered. On 11/3/2023 at 21:00, the documented BP was 90/63 and the nurse documented administering the medication. On 11/5/23 at 9:30 AM, the documented BP was 106/60 and the nurse documented held for parameters. The surveyor notified the administrator, chief nursing officer, and the interim director of nursing of the concern during a summary meeting on 11/14/23.	F 760		

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F 760	Continued From page 113	F 760		

4. For Resident #34, the facility staff failed to administer Coreg, a beta-blocker used to treat heart failure, on four separate occasions.

Resident #34's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 4, Alzheimer's Disease, Chronic Congestive Heart Failure, and Hypothyroidism.

The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 11/01/23 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired.

Resident #34's current physician's orders included an order dated 1/21/22 for Coreg 3.125 mg by mouth two times a day for congestive heart failure (CHF). The order did not include instructions to hold the medication based on any vital sign parameters.

According to Resident #34's clinical record, the Coreg was not administered on 10/30/23 at 9:00 AM. On 11/15/23 at 9:01 AM, surveyor spoke with licensed practical nurse (LPN) #3 regarding the 10/30/23 administration, LPN #3 stated the Coreg was not available in the medication cart or with the overstocked medications. Surveyor asked LPN #3 if they checked the stat box for available Coreg and LPN #3 stated they were not sure if they checked in the stat box.

Surveyor reviewed the facility onsite medication supply (stat box) list, the inventory listing included

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F 760	Continued From page 114 Carvedilol (generic for Coreg) 3.125 mg tablets. A review of Resident #34's November 2023 Medication Administration Record (MAR) revealed the Coreg was held on 11/03/23 8:00 PM (blood pressure (BP) 94/55), 11/05/23 9:00 AM (BP 139/50), and 11/08/23 8:00 PM BP 96/51). On 11/14/23 at 9:19 AM, surveyor spoke with the Chief Nursing Officer (CNO) regarding the resident's Coreg being held on multiple occasions and the CNO stated it was being held at those times due to nursing judgement related to the resident's blood pressure. On 11/14/23 at 2:30 PM, surveyor spoke with LPN #6 regarding holding the Coreg on 11/05/23 at 9:00 AM, LPN #6 stated they held the medication due to the resident's low blood pressure. LPN #6 acknowledged the order did not include parameters to hold the Coreg. LPN #6 stated they did not notify the physician but should have done so. On 11/15/23 at 9:16 AM, surveyor attempted to reach LPN #5 regarding holding the Coreg on 11/03/23 8:00 PM and 11/08/23 8:00 PM, however, the LPN was unavailable and did not return the call prior to the survey exit. On 11/15/23 at 8:58 AM, surveyor left a message to speak with Resident #34's physician, however, no return call was received prior to the survey exit. On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional Vice President of Operations and	F 760		

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F 760	Continued From page 115 discussed the concern of nursing staff failing to administer Coreg as ordered. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.	F 760		
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, the facility staff failed to store, prepare and distribute food in accordance with professional standards for food service safety. The findings include: On 11/13/23 at 4:20 PM during the initial tour of	F 812	F812 1) The center disposed of identified food/beverage items without labels, dates and/or improperly stored items upon discovering 11/13/23 and 11/14/23. 2) The Dietary Manager audited current food/beverage items for proper	12/27/23

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F 812	Continued From page 116 the kitchen with other staff member # 2, this surveyor observed a clear plastic container with a green lid in the reach in cooler. There was a pale yellow substance in the container. There was no label or date on the container. In the walk-in cooler, this surveyor observed a clear container with a red lid containing mushrooms. There was no label or date on the container. There was a chaffing pan containing macaroni and cheese that was not labeled or dated. The pan was half empty. There was a chaffing pan with 4 slices of ham and ground meat. The ham appeared very dry and there was no label or date. Both chaffing pans were loosely covered with plastic wrap. Other staff member # 2 was able to identify the contents of each container. They sated, "Everything should have been dated. I'll throw it all away." Surveyor interviewed the Interim Director of Dining Services who stated, "I pulled all those out this morning. I guess the staff didn't know why and just put them all back in there." On 11/14/23 at 10:45 AM this surveyor entered the nourishment room on unit B with the Interim Director. In the refrigerator, there was a tray with 6 sandwiches, two half sandwiches, 4 thickened water, 6 facility cups with lids manager stated they contained pudding. There were no labels and no dates on anything except one of the waters. One of the cups of water had a label on it with a resident name and a date of 11/8/23, indicating it was sent from the kitchen on that date. Surveyor asked if it was reasonable to assume the rest of the items were sent out on the same day, they stated, "I don't know, they should be dated and I will throw it all out." In the Unit A	F 812	labeling/dating and storage on 11/14/23. 3) The Administrator/Designee re-educated the current dietary staff and current nursing staff on proper food/beverage labeling/dating and storage on or before 12/27/23. 4) The Administrator/Designee will monitor the dietary food storage areas and unit food storage areas 3 times per week times 4 weeks for proper food/beverage labeling/dating and storage. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 812	Continued From page 117 refrigerator, there was a package of "hot and spicey chicken wings" with a use by date of 10/20/23 observed. These were discarded by the Dining Services Manager. This surveyor discussed the above concerns with the Administrator, Regional Vice President of Operations and the Chief Nursing Officer on 11/14/23 and requested a policy for food storage. The policy entitled, "Food Storage: Cold" was provided and read in part, "5. The Food Services Director/Cook insures that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." No further information was provided to the survey team prior to the exit conference.	F 812		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's	F 838		12/27/23

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F 838	Continued From page 118 resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.	F 838		

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F 838	Continued From page 119 §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents. The findings were: The administrator provided the survey team a facility assessment (FA) on 11/15/23 and reported to the team coordinator that the document had not been taken through the facility's quality program yet. On 11/16/23 at 12:27 p.m., a surveyor reviewed the FA and discussed with the administrator how the document did not have facility-specific information; the document looked to be the template of an assessment, not personalized. The administrator reiterated that the FA had not gone through their quality process yet and that he would speak with the facility's "clinical folks" and figure out what needs to be done. The administrator stated there had been a FA in the past and acknowledged the one provided to the survey team had not been individualized to indicate this facility's services etc. At the end of day meeting with the administrator, chief nursing officer, and regional vice president of operations, the concern regarding the facility assessment was discussed. No further information was provided prior to the exit conference.	F 838	F838 1. Facilty Assessment was reviewed and updated on 12/15/23 during QAPI. 2. The center identified the Facility Assessment had not been updated in 2023. The NHA/designee will ensure the Facility Assessment is reviewed and updated based on current resources needed to care for the residents. 3. The Regional Vice President of Operations will re-educate the NHA on the Facility Assessment policy on or before 12/27/23. 4. The NHA will review the Facility Assessment during the QAPI meeting. Additional interventions to be initiated as needed. 5. AOC: 12/27/23	

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F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		12/27/23

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F 842	Continued From page 121 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 5 of 22 residents, Resident's #71, #34, #46, #8 and #69. The findings included: 1. For Resident #71, facility staff failed to ensure Hospice documentation was maintained in the clinical record for review.	F 842	842 1) Resident #71 and #46 hospice records obtained by hospice representative on 11/14/23. Resident #8 no longer resides in the center. Resident #69 docusate dose was clarified on 11/16/2023 by licensed nurse. Resident #34 continues on Coreg medication and orders verified. Medication reviewed completed on 11/28/23.	

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F 842	Continued From page 122 Resident #71's diagnoses included, but were not limited to, benign prostatic hyperplasia, hypertension, and Alzheimer's. Section C (cognitive patterns) of Resident #71's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/17/23 was coded 1/1/3 to indicate the resident had problems with long- and short-term memory and was severely impaired in cognitive skills for daily decision making. Section O (special treatments, procedures, and programs) was coded to indicate this Resident was receiving Hospice services. Resident #71's comprehensive care plan included the focus area Hospice due to end of life care. During the clinical record review, the surveyor was unable to find any documentation from Hospice the Hospice staff. On 11/14/23 at 11:15 a.m., during an interview with the Unit Manager this staff stated the Hospice staff put their notes in a tablet and took them with them when they left the facility. On 11/14/23 at 12:50 p.m., during an interview with the Medical Records staff this staff stated they did not have a Hospice book for this resident. On 11/14/23 at 12:52 p.m., the Unit Manager stated the Hospice services had sent over the residents notes today and they did not have them at the facility prior to that. On 11/14/23 at 4:30 p.m., during an end of the day meeting with the Administrator, Regional Vice	F 842	2) The DON/Designee met with hospice rep on 11/14/23 to acquire current hospice resident's hospice records to be obtained by the center and a process for records retention going forward. The SSD will review current resident advance directives on or before 12/27/23 to validate completion. The DON/Designee will review the medication records for current resident's with orders for ducosate and coreg for accuracy with clarifications completed as needed on or before 12/27/23. 3) The DON/Designee re-educated the hospice representative and licensed nurses on hospice record availability in the center on or before 12/27/23. The DON/Designee re-educated the licensed nurses and SSD on advanced directive guidance, medication unavailable next steps and medication parameter guidance on or before 12/27/23. 4) The SSD will monitor 3 resident advanced directives per week times 4 weeks for completion. The SSD will monitor 3 resident hospice records when present in the center per week times 4 weeks for completion The DON/Designee will monitor 5 resident MARs per week times 4 weeks to validate medication availability and accuracy. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 842	Continued From page 123 President of Operations, and Chief Nursing Officer the missing Hospice information was reviewed. No further information regarding the missing Hospice documentation was provided to the survey team prior to the exit conference. 2. For Resident #34, the facility staff failed to ensure the clinical record was accurate regarding administration of Coreg, a beta-blocker used to treat heart failure, on three separate occasions. Resident #34's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 4, Alzheimer's Disease, Chronic Congestive Heart Failure, and Hypothyroidism. The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 11/01/23 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately	F 842		

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F 842	Continued From page 124 cognitively impaired. Resident #34's current physician's orders included an order dated 1/21/22 for Coreg 3.125 mg by mouth two times a day for congestive heart failure (CHF). The order did not include instructions to hold the medication based on any vital sign parameters. According to Resident #34's November 2023 Medication Administration Record (MAR), Coreg was held on 11/02/23 9:00 AM (blood pressure (BP) 140/65), 11/05/23 8:00 PM (BP 94/60), and 11/06/23 8:00 PM (BP 100/50). On 11/14/23 at 2:17 PM, surveyor spoke with licensed practical nurse (LPN) #7 regarding the 11/02/23 administration. LPN #7 stated the Coreg was not given because they thought the resident did not have any available, surveyor inquired if they checked in the stat box for any available Coreg and LPN #7 stated they did not look in the stat box. LPN #7 returned to the surveyor at approximately 3:30 PM and stated they now remember going and getting the Coreg and administering it to the resident but failed to document it. On 11/15/23 at 3:45 AM, surveyor spoke with LPN #4 regarding holding the Coreg on 11/05/23 and 11/06/23 and LPN #4 stated they held it due to the resident's low blood pressure. LPN #4 acknowledged the order did not include hold parameters but stated they contacted the on-call provider but failed to document it in the clinical record. On 11/15/23 at 8:58 AM, surveyor left a message to speak with Resident #34's physician, however,	F 842		

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F 842	Continued From page 125	F 842		

no return call was received prior to the survey exit.

Surveyor requested and received the facility policy titled "Medication Administration General Guidelines" which read in part "The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications ..."

On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of nursing staff failing to ensure accurate documentation regarding Coreg administration for Resident #34.

No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.

3. For Resident #46, the facility staff failed to ensure hospice documentation was present in the clinical record for review.

The findings were:

Resident #46's Admission Record listed the diagnoses as including but not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus, schizoaffective disorder, bipolar disorder, dementia, and Alzheimer's disease late onset. The significant change minimum data set (MDS) with an assessment reference date of 07/12/23 coded the resident's brief interview for

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F 842	Continued From page 126 mental status score of 06 out of 15 in Section C (cognitive patterns). Section O (special treatments, procedures, and programs) coded the resident as receiving hospice services. During Resident #46's electronic and paper clinical record review on, the surveyor was unable to locate documentation for provided hospice services. When nursing staff was asked where Resident #46's hospice documentation was kept, CNA #3 retrieved it from the unit manager and provided it to the surveyor. The documentation had been faxed to the facility from the hospice agency after another surveyor had requested hospice documentation for a different resident. During an end of the day meeting on 11/16/23 at 5:00 p.m., the concern about hospice documentation not being available in the resident's clinical record and the documentation was faxed to the facility after the survey team requested it was discussed with the administrator, chief nursing officer and regional vice president of operation. No further information regarding the missing hospice documentation was provided to the survey team prior to the exit conference. 4. For Resident #8 the facility staff failed to ensure the Virginia Department of Health Durable Do Not Resuscitate (DDNR) form was complete Resident #8's face sheet listed diagnoses which included but not limited to multiple sclerosis,	F 842		

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F 842	Continued From page 127 chronic pain syndrome, and pressure ulcer to sacral region. Resident #8's most recent minimum data set with an assessment reference date of 09/18/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #8's comprehensive care plan was reviewed and contained a care plan for "... has an Advance Directive as evidenced by: Do Not Resuscitate." Interventions for this care plan included "Obtain Advance Directive with physician order and resident/responsible party signature." Resident #8's clinical record was reviewed and contained a physician's order summary which read in part, "DNR-Do Not Resuscitate." Resident #8's clinical record contained a Virginia Department of Health DDNR form which read in part, "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical that he/she or a person authorized on the patient's behalf had directed that life-procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2):" Neither 1 nor 2 was checked. The concern of not ensuring a complete DDNR form was discussed with the administrator, chief nursing officer, and regional vice president of operations on 11/16/23 at 5 pm. No further information was provided prior to exit.	F 842		

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F 842	Continued From page 128 5. For Resident #69 the facility staff failed to ensure a dosage was included on medication order. Resident #69's face sheet listed diagnoses which included but not limited to type II diabetes mellitus, dysphasia, and hypertension. Resident #69's most recent minimum data set with an assessment reference date of 11/01/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #69's clinical record was reviewed and contained a physician's order summary which read in part, "Docusate Sodium Oral Tablet (Docusate Sodium). Give 1 tablet by mouth two times a day for stool softener." This order did not contain a dosage. Per Drugs.com, docusate sodium is available in 50 mg, 100 mg, and 250 mg dosages. The concern of the resident's medication order not containing a dosage was discussed with the administrator, chief nursing officer, and regional vice president of operations on 11/16/23 at 5 pm. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		12/27/23

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F 880	Continued From page 129 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 130 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview facility staff failed to ensure the IPCP program was reviewed annually. The surveyor was provided the Infection Control Program- Antibiotic Stewardship F881 policy and procedure with effective date 2/2017. The surveyor spoke with the regional vice president of operations (RVPO) about the need for an Infection Prevention and Control Program (IPCP) policy and for the policies to be reviewed and revised annually. The Antibiotic Stewardship Policy the RVPO had also was effective 2/2017 and had not been revised. RN#4, who became the acting ICP on 11/25/23, found a manual for Infection Control Program	F 880	F880 1) The center reviewed the revised Infection Control Program (ICP) during QAA meeting on 12/15/23. 2) No negative outcomes identified upon interdisciplinary team QAA review on 12/15/23. 3) The DON/Designee re-educated the interdisciplinary team (IDT) regarding annual review of the ICP in QAA meeting on 12/15/23. 4) The DON/Designee will review the ICP program upates weekly times 4 weeks. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed.	

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F 880	Continued From page 131 Version 4 revised October 2020. The October 2020 Version 4 represented the most recently revised infection control policies available in the facility. The surveyor repeated the concern with not reviewing and revising the Infection Contol Program manual annually during a summary meeting on 11/14/23 attended by the administrator, Director of Nursing and RVPO.	F 880	5) AOC: 12/27/23	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		12/27/23

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F 883	Continued From page 132 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical review facility staff failed to ensure the pneumococcal immunization was offered to 1 of 5 residents reviewed for immunizations (Resident #82). Resident #82 was admitted to the facility with diagnoses which included cerebral infarction with hemiplegia and hemiparesis, diabetes mellitus	F 883	F883 1) Resident #82 was offered the Pneumococcal vaccine on 12/06/2023 by DON and refused. 2) The DON/Designee reviewed and offered applicable immunizations to current residents on or before 12/27/23. 3) The DON/Designee re-educated the	

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F 883	Continued From page 133 type 2, atherosclerotic heart disease, and cardiopulmonary disease. On the most recent Minimum Data Set assessment with Assessment Reference date 10/4/23, the resident scored 11/14 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The resident's clinical record was reviewed for offer, education, and receipt of required vaccinations. The record indicated the resident received influenza vaccine October 2023 and Covid 19 Janssen in 2021 and a booster July 2023. There was no record of offering or receiving pneumococcal vaccine. The surveyor notified the Administrator and RVPO during a summary meeting on 11/15/23. No additional information concerning Resident #82 was offered.	F 883	licensed nurses on immunization guidance on or before 12/27/23. New admissions will be offered applicable immunizations upon admission by the admitting nurse/designee. 4) The DON/Designee will review 3 resident records for offering applicable immunizations and administration of immunization as ordered/accepted weekly times 4 weeks. Finding to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as	F 947		12/27/23

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F 947	Continued From page 134 determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide 12 hours of in-service training for nurse aides. The findings included: The facility staff failed to provide nurse aides with 12 hours of in-service training. On 11/15/23 at 8:26 a.m., the Administrator was asked for verification of 12 hours of training for 5 Certified Nursing Assistants (C.N.A.'s) #1, #2, #3, #4, and #5. On 11/15/23 at 9:10 a.m., C.N.A. #3 stated they had been employed at the facility over a year, they received training through a computer-based program and the training was appropriate. 11/15/23 at 9:23 a.m., the Administrator stated to the surveyor they did not have 12 hours of education for the employees that had been requested by the surveyor and they did not currently have a Staff Development Coordinator. On 11/15/23 at 9:36 a.m., during an interview with C.N.A. #6 this staff stated they received ongoing training and had the training they needed to complete their job duties. On 11/15/23 at 2:31 p.m., during an interview with C.N.A. #9 this staff stated they received training	F 947	F947 1) Current CNAs will complete 12 hour education/in-services on or before 12/27/23. 2) The Administrator/Designee reviewed current CNA records to determine due dates for completion of 12 hour education/in-services and notified current CNAs for timely completion 12/13/23. 3) The Administrator/Designee re-educated current CNAs on completion of 12 hour education/in-services and Relias program information 12/13/23. 4) The Administrator/Designee will review 3 CNA employee records per week times x 4 weeks to validate timely completion of required education/in-services. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	

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F 947	Continued From page 135 and there was always someone they could ask for help if needed. On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator, Regional Vice President of Operations, and Chief Nursing Officer the issue with the missing in-service training's were reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 947		