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	495235	A. BUILDING _____ B. WING _____	10/20/2023

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WILLIAMSBURG POST ACUTE & REHABILITATION	1235 S MOUNT VERNON AVENUE WILLIAMSBURG, VA 23185

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/17/23 through 10/20/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 130 certified bed facility was 72 at the time of the survey. The survey sample consisted of 39 resident reviews and 6 staff reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, facility documentation review, and clinical record review, the facility staff failed to assess and determine if a resident was safe to self-administer medications, for one resident (Resident #14) in a survey sample of 39 residents. The findings included: For Resident #14, who had medications stored in their room, the facility staff failed to assess if Resident #14 was safe to self-administer medications. On 10/17/2023 at approximately 12:40 p.m.,	F 554	1. Resident #14 was assessed as "not self-administering medications" on admission on September 13, 2022. A "Self-Administration of Medication Safety Evaluation" has been completed for Resident #14. 2. All residents who express a desire to self-administer medications/treatments are potentially at risk. The facility will conduct an audit of residents to determine which residents might desire self-administration of medication/treatments and complete Self-Administration of Medication Safety Evaluation as appropriate. 3. Licensed staff will be educated by the DON on the Residents' right to self-administer if the Interdisciplinary Team has determined that this practice is clinically appropriate.	12/5/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/27/2023

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

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F 554	Continued From page 1 observations were conducted of Resident #14's room. Resident #14 was not present in the room. It was noted that Resident #14 had a basket on the bed that contained two blister packets of medications. There was also a 3-drawer plastic storage unit against the wall that had clear drawers and it was observed there was a bottle of Tylenol and 2 cans of "jock itch spray" present. On 10/17/2023 at 1:33 p.m., Resident #14 was visited in her room. When asked about medications, Resident #14 said, the facility staff give her medications. On 10/18/2023, during mid-morning, observations were made in Resident #14's room. Resident #14 was present but asleep and unable to be aroused with verbal stimuli, which included knocking and calling out her name. Surveyor C noticed on the bed, in a basket were 2 blister packs of medications which were labeled as Mucinex and Nauzene. The clear 3-drawer storage unit contained Tylenol, Pepto Bismol, and jock itch spray. On 10/19/2023, during the early afternoon, Resident #14 was visited in her room again. All of the above noted medications were still present and in addition, Preparation H cream was noted sitting on top of the 3-drawer storage bin. Resident #14 was asked about the items, and she said she puts the Preparation H on herself. When asked where she obtained the items from, the resident was unsure. A review of Resident #14's entire clinical record, to include but not limited to, physician's orders, care plan, nursing notes, assessments, and interdisciplinary team meeting notes, there was	F 554	4. The facility Interdisciplinary Team (IDT) will complete Angel Rounds daily and audit resident rooms for cleanliness, homelike environment, privacy, and accommodation of needs, free of accident hazards, over-the-counter medication, and document on audit tool. Weekend supervisor/manager on duty on weekends. Rounds will be completed 3 times weekly. Angel rounds audits will be reviewed daily in the morning stand up meeting be turned into the facility Nursing Home Administrator. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC – 12/5/23	

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F 554	Continued From page 2	F 554		

no indication that Resident #14 had been assessed for his ability to self-administer medications. Resident #14 was initially admitted to the facility on 9/13/22 and readmitted on 6/21/23 following a hospitalization.

On 10/19/2023 at 11:21 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated they do not have any residents who self-administer medications. When asked about the protocol for this, the DON said, "If a Resident wanted to self-administer, I would speak to the doctor and do an assessment." When asked if there was a specific assessment that is used, the DON said, "Yes, there is an assessment and we would have them do a successful return demonstration, we would give them a supply [of medication being self-administered], we would check to make sure they have supply, and that they have given it properly." When asked where the medication that is being self-administered would be stored, the DON said, "In a lock box." When asked why a lock box is used to store the medications, the DON said, "Because I wouldn't want anyone else to have access to it," and confirmed they do have residents that wander and go into other residents' rooms.

During the above interview with the DON, she was asked to provide a copy of the facility policy regarding self-administration of medications and the assessment tool used to assess residents for this ability. On the afternoon of 10/19/2023, the facility policy and self-administration of medication assessment was received.

On the afternoon of 10/19/2023, the facility Administrator, Director of Nursing, and Corporate

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staff were made aware that Resident #14 was not assessed for the ability to self-administer medications and medications were noted at the bedside. The Corporate Nursing Consultant advised Surveyor C that the Administrator had found 2 bottles of vodka in Resident #14's room and had to remove them. They felt Resident #14's daughter was providing/putting the items in Resident #14's room to sabotage the survey. Of note, Resident #14's daughter is also a resident of the facility.

A review was conducted of the facility policy titled, "Self-Administration of Medications and Treatments." Excerpts from the policy read, "Policy: Residents have the right to self-administer medications/treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Specific Procedures/Guidance: 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities and choice to determine whether self-administering medications and/or treats is clinically appropriate for the resident...3. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment. 8. Self-administered medications and/or treatments will be stored in a safe and secure place, which is not accessible by other residents. "

On 10/20/2023, prior to conclusion of the survey, the facility staff provided the survey team with a listing of items removed from Resident #14's room, which included the following: Mucinex, Pepto Bismol, acne treatment, Preparation H gel, Tylenol, Diclofenac Gel,

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F 554	Continued From page 4 Preparation H cream, jock itch spray, Nauzene, Salonpas patches, which are all over the counter medications. No further information was provided.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility staff interview, clinical record review, and facility documentation review, the facility staff failed to accommodate the needs of 2 residents (Residents #274 and #70) in a survey sample of 39 residents. The findings included: 1. For Resident #274, who was unable to get out of bed without assistance, the call bell was not in reach; therefore, leaving the resident with no way to call facility staff for assistance. On 10/17/2023 at 1:45 p.m., Resident #274 was visited in his room. The resident was noted to be alert, oriented x4 and a good historian upon interview. The resident was observed lying in bed, was noted to be a bilateral amputee of lower extremities. Resident #274 said, his call bell is the only way he can call for assistance and frequently it is out of reach or has fallen behind the bed. He	F 558	1. The facility ensured that residents had call lights within reach for all residents affected. Call light clips were replaced, and all call lights checked for functionality. 2. All residents of the facility have the potential to be affected by this deficient practice. The facility will conduct an audit of all resident rooms and common areas to ensure that call lights are in good working order. 3. Staff of the facility will be educated by the DON on the company policy on resident rights and accommodation of needs and the importance of call lights being within reach for all residents.	12/5/2023

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F 558	Continued From page 5 said he frequently has to get his roommate to use his call bell to get assistance to the room. Resident #274 reports he does not get out of bed. On 10/17/2023 at 1:49 p.m., an interview was conducted with CNA B. CNA B was asked about the call bells, to explain their purpose, and where they are located. CNA B said, "The call bell is how the residents let us know if they need something. If they can't get out of bed, that is the only way they can call for assistance other than staff checking on them regularly." CNA B accompanied Surveyor C to the room of Resident #274 and confirmed the call bell was laying on the bed frame at the foot of the bed and out of reach of the resident. CNA B further confirmed the resident had no way of calling staff for assistance if he had needed it. A clinical record review of Resident #274's chart was conducted on 10/17/2023. This review revealed that he was dependent on facility staff for activities of daily living (ADL). There was a care plan initiated on 10/08/2023, that indicated Resident #274 "Is at risk for falls r/t [related to] bilateral BKA's [below knee amputations]." One intervention listed read, "Be sure The [sic] resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Review of the facility policy titled, "Answering the Call Light" was conducted. An excerpt from the policy read, ". 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the Resident. " On 10/17/2023 during an end of day meeting, the	F 558	4. The facility Interdisciplinary Team (IDT) will complete Angel Rounds daily and audit resident rooms for cleanliness, homelike environment, privacy, and accommodation of needs, free of accident hazards, over-the-counter medication, and document on audit tool. Weekend supervisor/manager on duty on weekends. Rounds will be completed 3 times weekly. Angel rounds audits will be reviewed daily in the morning stand up meeting be turned into the facility Nursing Home Administrator. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 12/5/23	

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F 558	Continued From page 6 facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided. 2. For Resident #70, the call bell was located beyond his reach, making it unavailable for him to call for assistance. On 10/17/2023 at approximately 1:35 p.m. during initial tour, Resident #70 was observed lying awake in his bed with his call bell located on the floor at the foot of his bed. When asked if he knew where his call bell was, he felt around his bed and shook his head, "No." Resident #70 was unable to speak due to previous history of a stroke. LPN B, assigned to Resident #70's unit, was asked to come into Resident #70's room. LPN B was asked if she thought Resident #70 could reach his call bell to call for assistance, and she stated, "No, he cannot get to that [the call bell], it should be kept within his reach at all times so he can use it. He cannot speak but he does know how to use his call bell." LPN B picked the call bell up off the floor and secured it to Resident #70's bedspread within his reach. On 10/17/2023, a facility policy regarding call bells was requested and received. The facility policy entitled, "Answering the Call Light," item 5 read, "When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident." On 10/17/2023, the Facility Administrator and Director of Nursing were updated on the findings.	F 558		

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F 558	Continued From page 7 No further information was provided.	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility staff failed to post in a readily accessible place, inspection reports with a plan of corrections in effect, with respect to any surveys conducted during the past 3 years for all 72 residents residing in the facility. The facility's non-compliance has the potential to impact all	F 577	1. The survey results book in the lobby was immediately updated to remove draft versions and all 2567 survey results and facility accepted plans of correction are up to date. 2. All residents of the facility have the potential to be affected by this alleged deficient practice. 3. All staff will be provided education by the DON on resident rights and the importance of survey results being available to residents and families of the facility. 4. The NHA/designee will conduct audits weekly of the survey binders to ensure that the required 3 years of survey cycles results are present in the lobby. The results of the audits will be reported to the QAPI committee monthly x 3 months. The QAPI committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	12/5/2023

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F 577	Continued From page 8 residents and their family's ability to make informed decisions regarding knowledge of the facility's regulatory compliance history. The findings included: 1. The facility staff failed to have readily accessible to residents and family members, the survey results with any plan of correction in effect for the surveys conducted for the past 3 preceding years. On 10/18/2023 at 1:24 p.m., Surveyor C observed the facility's survey results which were in the lobby, outside of the entrance to the dining room. It was noted that multiple survey reports (CMS [Centers for Medicare & Medicaid Services] form 2567) had a watermark that read, "POC [Plan of Correction] Not Final" across the page. The following survey reports were noted to be incomplete: a. An abbreviated survey conducted 06/13/2023 - 06/14/2023, the CMS 2567 report had the watermark, and no plan of correction was noted. There was a separate sheet of paper, which was untitled, that had the plan of correction behind the CMS form. b. A standard survey and emergency preparedness survey conducted 11/01/2022 - 11/04/2022, was not signed and had no plan of correction for the identified deficiencies cited. c. A standard survey report from 11/01/2021 - 11/04/2021, had no plan of correction noted and the pages did not have the water mark.	F 577		

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F 577	Continued From page 9 d. A Life Safety survey conducted on 9/20/21, had no plan of correction noted. e. A standard survey conducted 09/15/2021 - 09/17/2021, the CMS 1567 report had the "POC Not Final" water mark across the pages and no plan of correction was identified. f. A state licensure survey performed on 09/15/2021 - 09/17/2021, had the watermark and no submitted plan of correction. g. An abbreviated standard survey was conducted 08/09/2021 - 08/11/2021. This CMS 2567 form again had the "POC Not Final" watermark, and no plan of correction was noted. On 10/18/2023 at 3:55 p.m., an interview was conducted with the facility Administrator. The Administrator was asked to explain survey results posting. The Administrator said, "We have to display the past 3 years of surveys and the POC for the deficiencies for those surveys for residents and families to look at." The Administrator was then asked why it is important to have that information available to residents and families. The Administrator said, "So they can know what deficient practice the facility was cited for and their plan to come back into compliance." During the above interview, the survey result books were then presented to the Administrator, and he was asked to look through them. It was pointed out that many of the survey report forms had a watermark that indicated the plan of correction was not complete, and no plan of correction was noted. The Corporate Clinical Consultant spoke up and said, "We can't access	F 577		

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F 577	Continued From page 10 the older ones," indicating the facility was under a prior owner at that time; therefore, they could not obtain those past reports. On 10/18/2023 at approximately 4:05 p.m., Surveyor C went to the Administrator to provide the website for the State Survey Agency where previous survey inspection reports (CMS 2567) forms can be accessed. The Administrator stated, "Oh yeah, I use those for insurance purposes," indicating he was familiar with the website and had accessed the survey reports from that site previously in another capacity. On 10/18/2023, prior to the end of day meeting, the facility Administrator confirmed with Surveyor C that he was printing the last completed survey report form to update the binder. The facility policy titled, "Resident Rights" was reviewed. The policy stated, ". 18. The Resident has a right to examine the results of the most recent survey of the Facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the Facility... " On 10/18/2023 during an end of day meeting, the facility administrator and Director of Nursing (DON) were made aware of the missing survey reports. No further information was provided.	F 577		
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,	F 580		

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F 580	Continued From page 11 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580	1. Resident #14s medication change in medication was reviewed the resident's responsible party. 2. An audit has been performed of changes in medication in the last 2 weeks to identify other residents at risk for not notifying responsible parties (RP) of medication changes. Any RP notifications for resident medication changes have now been made and are documented. 3. The Director of Nursing/Designee will reeducate LPNs, and RNs on the importance of notifying an RP of a significant change in condition and/or need to alter treatment in a timely manner. This education will include, but not limited to notifying the RP of a change in medication.	12/5/2023

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	495235	A. BUILDING _____ B. WING _____	10/20/2023

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F 580	Continued From page 12 §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 observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to notify the physician and family of a resident's change in medications and change in condition for one resident (Resident #14) in a survey sample of 39 residents. The findings included: For Resident #14, who had a medication change which was not communicated to the family, there was a noted increase in sleeping and she was difficult to arouse following the start of an antipsychotic medication. The facility staff failed to notify the doctor and family member of the change until prompted by survey team. On 10/17/2023, Resident #14 was visited in her room by Surveyor C. Resident #14 was awake, able to engage in conversation with no difficulty, and appeared to have some memory loss. There was no obvious significant hearing deficit noted. On 10/18/2023, Surveyor C visited Resident #14's room on 3 occasions, once mid-morning, once early afternoon, and lastly around 3:30 p.m. Each time, Surveyor C knocked on the resident's room door, entered the room, and called the resident's name. The resident was observed laying on her bed asleep. Surveyor C got closer to the resident and called her name again,	F 580	4. The Director of Nursing/Designee will perform an audit on 5 of residents weekly for 8 weeks to ensure timely notification of RPs of change in medication. The results of the audits will be reported to the QAPI committee monthly x 3 months. The QAPI committee is responsible for the on-going monitoring of compliance. 5. DOC – 12/5/23	

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F 580	Continued From page 13 Resident #14 did not arouse. On 10/18/2023 at approximately 3:30 p.m., Surveyor C interviewed CNA D. CNA D was in the hallway outside of Resident #14's room, and was filling a water pitcher with ice. CNA D was asked about Resident #14 and asked if she normally sleeps a lot. Surveyor C explained that she had attempted to visit the resident on several occasions, but Resident #14 would not arouse. CNA D said he was in the hall filling the water pitcher to not awaken the resident. He said that normally she is awake. On 10/19/2023 at approximately 8:30 a.m., Surveyor C went to visit Resident #14 in her room again. Surveyor C knocked on the door, entered the room, and called the resident's name. Resident #14 did not respond. Surveyor C approached the bedside and observed Resident #14 asleep on top of the covers, with her dentures protruding from her mouth. Surveyor C again called Resident #14's name, with no response. On 10/19/2023 at approximately 9:00 a.m., Surveyor C interviewed CNA B and CNA E. They were asked if Resident #14 usually sleeps a lot and is hard to arouse. They said she does sleep at times but is easily aroused. They were informed that Surveyor C had made multiple attempts to visit the resident yesterday and again this morning, but Resident #14 was asleep and not responding to her name being called. They stated this was not the resident's normal behavior, but she had awakened for breakfast. On 10/19/2023, an interview was conducted with CNA F. CNA F was asked about Resident #14.	F 580		

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F 580	Continued From page 14 CNA F said he was not too familiar with the resident's pattern, but knew she stayed in her room a lot and would doze on and off at times. On 10/18/2023 - 10/19/2023, a clinical record review was conducted. A progress note dated 10/16/2023, read, "Resident was seen by her outside PCP today. New order for Sulfamethoxazole 400 mg- Trimethoprim 80 mg, 1 tab every 8 hours x 7 days. Also an increase in Quetiapine/Seroquel to 50 mg once a day at bedtime." There was no indication Resident #14's family member had been notified of the start of an antipsychotic medication. Review of the Medication Administration Record (MAR) for October 2023 revealed that Resident #14 was not receiving Seroquel prior to 10/16/2023. Resident #14 did receive a dose on 10/17/2023 and 10/18/2023. Physician's orders and the MAR revealed that that Resident #14 was started on Sertraline HCl oral tablet, (also known as Zoloft, which is an antidepressant) 50 mg, once daily for depression symptoms starting 08/12/2023. At the time of survey, this medication continued. Review of the progress notes revealed no evidence of any behaviors in the past 30 days that would have precipitated the medication change. On the afternoon of 10/19/2023 during an end of day meeting, the facility Administrator, Director of Nursing, and corporate staff were made aware of the above concern that Resident #14 was displaying significant somnolence and had a recent medication change that may be a	F 580		

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F 580	Continued From page 15 contributing factor as well as the over-the-counter medications that were noted in the room, since they are unaware of what and how much the resident may be self-administering. A copy of the physician's progress notes from 10/16/2023 was requested. On 10/20/2023 during the morning, Resident #14 was visited in her room and was sitting at the bedside and awaiting her breakfast. She was talkative and able to engage in conversation. On the morning of 10/20/2023, Surveyor C requested the physician's progress note from 10/16/2023. A clinical record review was conducted again and revealed that following the end of day meeting held on 10/19/2023, the facility staff had completed an "SBAR Communication Form," which indicated Resident #14 had a change in "Altered level of consciousness," which was reported to the physician. In response to this, an order was received to change the dosage of the Seroquel to decrease it to 25 mg daily at bedtime. On 10/20/2023 in the afternoon, the facility staff provided Surveyor C with the physician's progress note from 10/16/2023. It was reviewed and there was no indication for the medication, Quetiapine, other than diagnosis listed on a "Report of Consultation" that included, "compulsive behavior, and generalized anxiety." There were no other details given as to why the Quetiapine/Seroquel was being ordered. No further information was provided.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		

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F 582	Continued From page 16 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582	1. The facility is unable to make corrections to the ABN notices for resident #21 and 43 that were issued since the date is in the past. 2. All residents of the facility have the potential to be affected by this deficient practice. The facility will conduct an audit of all ABN notices issued in the past 30 days to ensure the proper form was used in giving notice. 3. Staff of the facility will be educated by the DON on resident rights that include the ABN notice with proper timeframes for issuing notice and most up to date CMS forms. 4. The facility Administrator will conduct and audit of 3 ABN notices weekly to ensure proper ABN Notice forms and notices were issued in proper timeframe. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 12/5/23	12/5/2023

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F 582	Continued From page 17 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide a proper Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) to 2 residents (Residents #43 and #70) in a survey sample of 3 residents reviewed for such notices. The findings included: For Residents #43 and #70, the facility staff failed to utilize a CMS approved SNF ABN form, which provided the option for the resident to select/choose to continue services and pay for the care without Medicare being billed. On 10/17/2023, the facility Administrator was asked to provide a listing of residents who were discharged from Medicare Part A services, prior to exhausting their benefit days. From this listing, a sample of 3 residents was selected, which included Residents #43 and #70. The notices issued to these residents was requested and received.	F 582		

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F 582	Continued From page 18 Review of the SNF ABN forms revealed the following: 1. For Resident #43, the facility staff provided a SNF ABN notice on 09/11/2023, which indicated "therapy services" were ending. The form provided Resident #43 with 2 options to select from. The Centers for Medicare & Medicaid Services (CMS) approved form provides 3 options. 2. For Resident #70, the facility staff provided a SNF ABN notice on 09/11/2023, which indicated "therapy services" were ending. The form provided Resident #70 with 2 options to select from. The Centers for Medicare & Medicaid Services (CMS) approved form provides 3 options. The form provided to Residents #43 and #70, as indicated above, only offered them 2 options to choose from. The options given read as follows: "Option 1. YES. I want to receive these items or services. I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision. Option 2. NO. I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your option that Medicare won't	F 582		

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F 582	Continued From page 19 pay. I understand that, in the case of any physician-ordered items or services, should notify my doctor who ordered them that I did not receive them." On 10/18/2023 at 4:13 p.m., an interview was conducted with Employee F, the Social Services Director, and Employee J, the social worker. Both employees stated they are responsible for issuing Advance Beneficiary Notices (ABN). When asked to explain the purpose of the form, Employee F said, "With a part A you also do a SNF ABN to go with the NOMNC (Notice of Medicare Non-Coverage)." Employee F went on to say, "The NOMNC is 2 pages and the ABN, which is 1 page, says after this date you will incur a fee between $150-$300 for therapy if you decided to stay and do therapy, after this day you either go home or decide I'm going to be here long-term care." Both Employees F and J indicated the notices are issued 48 hours before the last covered day. Both employees further confirmed the SNF ABN form has 3 options for the resident to choose from. During the above meeting, Employees F and J were shown the notices provided to Residents #43 and #70, which only indicated 2 options. Both employees stated they were not aware of and had not noticed the change and confirmed it was not the CMS approved form issued. The facility policy titled, "Medicare Liability Notice" was reviewed. It read, "...4) The Social Worker, Business Office representative, or designee will; fully complete the required liability notice and provide it to the beneficiary/beneficiary representative prior to stopping the Medicare coverage. 5. The facility will utilize and follow the	F 582		

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F 582	Continued From page 20 Medicare approved notices and instructions..." The approved CMS form "CMS-10055" titled, "Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN)" was reviewed. The facility's Social Services Director, Employee F, provided Surveyor C with a blank form. The CMS approved form had 3 options for the beneficiary to choose from. The options read as follows: "OPTIONS (Check only one box. We can't choose a box for you).: Option 1: I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN. Option 2: I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed. Option 3: I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay." The Centers for Medicare & Medicaid Services (CMS) provides facilities with the following guidance document titled, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055." An excerpt from this document read, "...Completing the SNF ABN: The SNFABN is available for download by selecting the "FFS SNFABN" link from the menu on the webpage http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html. The SNFABN is a CMS-approved model notice and should be replicated as closely as possible when used as a mandatory notice. Failure to use this notice or	F 582		

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F 582	Continued From page 21 significant alterations of the SNFABN could result in the notice being invalidated and/or the SNF being held liable for the care in question..." Accessed online at: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-snf-abn On 10/18/2023, the facility Administrator was made aware of the above findings. No further information was provided.	F 582		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation, the facility staff failed to ensure freedom from abuse and neglect for 1 resident (Resident #54) in a sample of 39 residents. The findings included:	F 600	1. Resident #54 incident from 7/20/23 was reported to VDH on 10/20/23. 2. All residents of the facility have the potential to be affected by this alleged deficient practice. An audit was conducted on all grievances filed in the past 90 days to ensure no other grievances filed should have been reported as an allegation of abuse. 3. All staff of the facility will be provided with education by the DON on the facility abuse and neglect policy that includes types of abuse and protection of residents from abuse. This will include timely reporting of abuse in accordance with the facility policy and the Elder Justice Act.	12/5/2023

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F 600	Continued From page 22 For Resident #54, the facility staff failed to ensure the resident was not verbally abused by a CNA who threatened to, and did in fact, neglect the resident's needs. Resident #54 is a 92-year-old resident with diagnoses of, but not limited to, bradycardia, chronic kidney disease Stage 3, chronic obstructive pulmonary disease, history of falls, hypertension, muscle weakness, unsteady on feet, muscle wasting and atrophy. On 10/17/2023, a review of the facility grievance log revealed that on 07/20/2023, Resident #54 was threatened by CNA who stated, "If you ring that call bell, I am NOT going to answer it." This grievance was written in the grievance book by the Social Worker (Employee F). A review of the complaint/grievance report read as follows: "Resident was wanting air conditioner turned up and felt like he was abruptly handled. Stated that aid told him if he puts his call light on, they will not answer it. Upset and smelled of urine. [dated 7/20/23]. Resident was saturated and upset about getting a shower to be cleaned up. He is ok now. [dated 7/20/23] Resident given shower and is ok at this time. No issues after shower. [signed by unit mgr. dated 7/20/23]." A review of the clinical record revealed there were no progress notes for 07/20/2023 addressing this situation. On 10/19/2023 at approximately 2:00 p.m., an	F 600	4. The facility administrator will audit grievances weekly for 4 weeks and then monthly for 2 months to ensure that no grievances that were filed meet the criteria for an allegation of abuse or neglect. Results of audits will be submitted monthly to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. **5.** DOC- 12/5/23	

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F 600	Continued From page 23	F 600		

interview was conducted with Resident #54 who stated that on the day of the incident he was wanting the air conditioner turned up and the CNA told him if he rings the call bell, they will not answer it. When asked how that makes him feel, he stated, "I hear stuff like that all the time around here." Resident #54 stated he was also in need of incontinence care, but the staff failed to answer the call bell. He stated he ended up having to get a shower to get cleaned up because they waited so long to change him. The resident stated he complained to the Social Worker about it. Resident #54 was not able to recall who the staff member was that threatened to not answer the call bell. Resident #54 went on to state he had the Social Worker purchase prune juice to keep in his room because the staff would not give it to him when he asked for it. He stated they would sit at the nurses station and ignore the call bell to the point he would have to wheel himself to the nurses' station, which has a high wall, and Resident #54 could not see over it while in his wheelchair, so he would have to go around the side to see if anyone was at the nurses' station. He stated many times they would be quiet and not answer until he went around the side and could see they were there.

On 10/19/2023, an interview with the Social Worker was conducted, and he stated he did not identify this incident as abuse or neglect; therefore, did not escalate it up to an abuse allegation.

On 10/19/2023 at 6:28 p.m., an interview was conducted with the Administrator and Employee C (Corporate Clinical Nurse Consultant). They were asked if the Social Worker/Grievance Officer should be able to identify and report

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F 600	Continued From page 24 abuse and neglect. The Administrator stated that all the staff should be able to identify and report abuse and neglect. The Administrator and Employee C were shown the grievance report from 07/20/2023 involving Resident #54 and agreed it was a threat to neglect the resident. When asked if this incident was investigated, the Administrator stated it had not been. When asked if this was reported to the appropriate offices, the Administrator stated it had not been. On 10/19/2023, a review of the facility's abuse policy read as follows: Page 1 Paragraph 1 "Definitions: ABUSE is also the deprivation by an individual, including a caretaker, of good or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing." On 10/19/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility staff	F 602	1. Resident #14 was moved closer to the nurses station to accommodate supervised access on October 19, 2023. Resident #55 (daughter to resident #14) no longer resides at the facility.	12/5/2023

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F 602	Continued From page 25 interview, clinical record review, and facility documentation review, the facility staff failed to protect one resident (Resident #14) from misappropriation of property in a survey sample of 39 residents. The findings included: For Resident #14, the facility staff failed to protect the resident from a known perpetrator, who had been identified by the facility as a verbal abuser and who had previously financially exploited the resident. The facility staff continued to permit unsupervised and unrestricted access to Resident #14 and her personal possessions by the known perpetrator, which allowed the perpetrator to gain access to Resident #14's bank cards when she had no legal right to possess the items. On 10/17/2023 in the afternoon, Resident #14 was visited in her room. During the interview/conversation, cognitive impairment and difficulty with memory recall was noted. The resident did acknowledge she had been to visit her daughter earlier in the day. Resident #14's daughter is also a resident of this facility. Resident #14 reported they are able visit each other anytime they want. Review of the facility's investigation documents revealed that on 02/03/2023, there was an incident between Resident #14 and her daughter, Resident #55. The incident was witnessed by 2 staff members and involved Resident #55 being verbally abusive to Resident #14. The facility's investigation findings concluded, "The investigation showed that [Resident #55's name redacted] did verbally abuse her mother and	F 602	2. All residents of the facility have the potential to be affected by this alleged deficient practice. Facility will audit residents to identify if any other residents have limited or supervised access to any other residents, staff, visitors, etc. 3. All staff of the facility will be provided with education by the DON on the facility abuse and neglect policy that includes types of abuse and protection of residents from abuse. This will include timely reporting of abuse in accordance with the facility policy and the Elder Justice Act. 4. The administrator or designee will audit any residents identified as having limited or supervised access weekly for 4 weeks and then monthly for 2 months to ensure protection is provided as plan of care. Results of audits will be submitted monthly to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC – 12/05/23	

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F 602	Continued From page 26 upset her...APS [Adult Protective Services], the physician and local police were notified." In conclusion, the facility stated, "The facility substantiated this verbal abuse due to the relationship of these two individuals it is tough to hold tight on interventions because of resident rights and the mother daughter relationship." On 06/29/2023, the Social Worker wrote a progress note that read, "[Resident #14's name redacted] met with the city of [City name redacted] Adult Protective Services social worker, [APS worker's name redacted], the Director of Nursing, Social Services, and the Business Office Manager to review bank statements. [APS worker's name redacted] reviewed transactions on the bank statements that displayed funds that were being utilized for means not pertaining to [Resident #14's name redacted]'s stay in the facility. [Resident #14's name redacted] expressed that she "did not want to get her daughter into any trouble or arrested." The Director of Nursing comforted [Resident #14's name redacted] by stating that the purpose of the meeting was for to ensure that the facility was being a good steward of the Medicare and Medicaid process in an effort to protect the best interest of [Resident #14's name redacted]. [Resident #14's name redacted] verbalized that she does not want her daughter to control her money anymore. She also stated that she wants to revoke her power of attorney on file. [APS worker's name redacted] stated that she would attempt to collaborate with an outside organization to revoke the power of attorney and enter into a fiduciary agreement with [Resident #14's name redacted] to make sure her funds are used for her stay in the facility. [Resident #14's name redacted] was in complete agreement as	F 602		

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F 602	Continued From page 27 she stated, "I have never dealt with money in my life." She also authorized for her Social Security checks to be direct deposited into her Resident Fund Management Services account. [APS worker's name redacted] praised the staff for providing excellent care. Social Services will continue to monitor." Another entry by the Social Worker was made into Resident #14's chart on 07/06/2023. This entry read, "Social services was given the paperwork with the new POA [power of attorney] information that was orchestrated with the assistance of APS [Adult Protective Services]. The son of the resident is now the current POA which was awarded to him by his mom [Resident #14's name redacted], and the paperwork has been uploaded into [name of electronic health record system redacted]. Social services will continue to monitor the resident at this time." According to facility investigation documents, on 07/27/2023, Resident #55 "Alerted staff that she called the police because a bag with clothes and purse were taken from her mother's room and given to her and she believed that items may have been stolen out of the purse, but she holds her mother's debit, medical and identification cards..." Also in the investigation documents was a typed "timeline" dated 07/27/2023. This document read, "At 9:30 this writer [writer did not sign document, so unaware of who the writer was] was called to the front lobby to meet [Resident #55's name redacted]...[Resident #55's name redacted] called police to say [Resident #14's name redacted] purse was taken out of her room and taken to laundry and then brought to her [Resident #55]	F 602		

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room. The purse was in a clear bag with [Resident #14's name redacted] soiled clothes from the hospital.... Writer spoke with [Resident #55's name redacted] and asked her to identify the housekeeper that brought her the purse. [Resident #55's name redacted] identified the housekeeper. This writer asked the housekeeper how she got the clear bag and the items in it, and she stated that the evening CNA brought it down to be laundered [sic]. "

Also in the document titled, "timeline," was the following statement, "The police officers and APS worker and this writer interview [sic] [Resident #14's name redacted] if she gave [Resident #55's name redacted] her debt [sic] cards before she went to her doctor's appointment on 7/26/2023 or she had them taken from her by [Resident #55's name redacted]. [Resident #14's name redacted] stated she gave them to [Resident #55's name redacted] to hold. [APS worker's name redacted] reeducated [Resident #14's name redacted] that [Resident #55's name redacted] is not the power of attorney, and she is not authorized to hold her debit cards."

The investigation summary stated, "After investigation was completed by Local Police Department and Local Adult Protective Services were on site to obtain the debit cards from [Resident #55's name redacted] as this resident is not the Power of Attorney for [Resident #14's name redacted] because of prior financial exploitation. In work with the Local Police Department and Local Adult Protective Services they will be reopening the case on [Resident #55's name redacted] of financial exploitation of [Resident #14's name redacted] and will subpoena financial records for both [Resident #14

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F 602	Continued From page 29 and #55's names redacted] ..." In Resident #14's clinical record there was a progress note dated 07/27/2023, written by the Director of Nursing. It read, "Medical Director notified by this RN that Residents purse was misplaced for a short period of time. Resident stated that nothing was missing from purse. It was later identified that Residents daughter had obtained cards from Residents purse. APS [adult protective services] notified [City name redacted] Police and both entities as well as Residents RP [responsible party/son] came to the Facility. APS and [police department name redacted] initiated an investigation. Medical Director verbalized understanding of all information provided, no questions or concerns voiced." Therefore, it is unclear how Resident #55's obtained Resident #14's bank cards, but the facility staff allowed unrestricted and unsupervised access between the two residents which permitted Resident #55 to have access to Resident's #14's personal possessions. Review of Resident #14's care plan revealed no mention of the prior abuse between Residents #14 and #55, the relationship of the two, or any other problems. Within Resident #14's clinical record was a document titled, "Psychological Assessment," with an evaluation date of 08/18/2023. This document read, "...Reason for Referral: [Resident #14's name redacted] was referred for assessment by [City name redacted] Department of Social Services to help determine her need for guardianship assistance. Specific concern was expressed that a seeming inability to monitor her	F 602		

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finances was leaving her open to financial exploitation..." The document went on to read, "...Conclusions and Recommendations: [Resident #14's name redacted] is demonstrating a range of cognitive declines/deficits consistent with early-stage and progressing dementia. She currently appears incapacitated to the point that she will need another person to make decisions for her regarding her personal affairs to include residential planning, medical care, and all aspects of her finances. [Resident #14's name redacted] is capable of offering limited input regarding her preference of where she might live but cannot make sound living arrangement/residential placement decisions (and is easily misguided in that area). Her cognitive deficits are ones for which she will be unable to make improvements. That is, there is no known treatment by which they can be remedied to any meaningful extent, and instead, her deficits can be expected only to worsen over time. [Resident #14's name redacted] appears in need of legal guardian to manage her personal and financial affairs. She appears to possess the capacity to grasp that nature of a guardianship and conservatorship but lacks the ability to intelligently consent to the appointment of a guardian or conservator. The above is true and correct to the best of my information and belief... [signed by a Licensed Clinical Psychologist, whose name is redacted]."

Throughout the course of the survey, it was noted that Resident #14 had multiple over-the-counter medications in her room. On the afternoon of 10/19/2023, the facility Administrator, Director of Nursing, and Corporate staff were made aware that Resident #14 had multiple over-the-counter medications at the bedside. The Corporate Nursing Consultant advised Surveyor C that the

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Administrator had removed 2 bottles of vodka from Resident #14's room earlier that day. The administrative staff reported to the survey team that Resident #14's daughter, Resident #55, was the one giving Resident #14 items.

On 10/19/2023 during the end of day meeting, an interview was conducted with the facility Administrator, Director of Nursing and Corporate Nursing Consultant. During the interview, the survey team shared concerns regarding Resident #55 and Resident #14. The administration was asked what steps they were taking to protect Resident #14's safety.

In response to the survey team's shared concerns, on the morning of 10/20/2023, the facility Administrator and Corporate Nursing Consultant reported to the survey team that on the evening of 10/19/2023, following the end of day meeting with the survey team, Resident #14's room assignment had been moved directly across from the nursing station for closer monitoring. Additionally, a staff member had been assigned to Resident #14 as one-to-one, to supervise any visits between Resident #14 and Resident #55 to ensure there was no exchange of items or items being brought into Resident #14's room that were not permitted.

On 10/20/2023, interviews were conducted with CNA B, LPN D and LPN C, the unit manager. All three stated that prior to 10/20/2023, Residents #14 and #55 have been permitted to have unrestricted and unsupervised visits with each other ad lib [as they choose].

The facility policy titled, "Abuse," was reviewed. Excerpts from the policy read, ". 6. Protection: a.

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F 602	Continued From page 32 In the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident. b. The resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury or harm identified through assessment of the resident..." No further information was provided.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)	F 607	1. Resident #54 incident from 7/20/23 was reported to VDH on 10/20/23. Resident #14 was moved closer to the nurses station to accommodate supervised access on October 19, 2023. Resident #55 (daughter to resident #14) no longer resides at the facility. 2. All residents of the facility have the potential to be affected by this alleged deficient practice. An audit was conducted on all grievances filed in the past 90 days to ensure no other grievances filed should have been reported as an allegation of abuse. The facility will audit residents to identify if any other residents have limited or supervised access to any other residents, staff, visitors, etc.	12/5/2023

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F 607	Continued From page 33 (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility staff interview, clinical record review, and facility documentation, the facility staff failed to implement the abuse, neglect, and exploitation policy for 2 residents (Residents #54 and #14) in a survey sample of 39 residents. The findings included: 1. For Resident #54, the facility staff failed to implement the abuse/neglect policy when Resident #54 reported to the Social Worker an allegation of abuse/neglect. Resident #54 is a 92-year-old resident with diagnoses of, but not limited to, bradycardia, chronic kidney disease Stage 3, chronic obstructive pulmonary disease, history of falls, hypertension, muscle weakness, unsteady on feet, muscle wasting and atrophy. On 10/17/2023, a review of the facility grievance log revealed that on 07/20/2023 Resident #54 was threatened by CNA who stated, "If you ring that call bell, I am NOT going to answer it." This grievance was written in the grievance book by the Social Worker (Employee F). A review of the complaint/grievance report read as follows: "Resident was wanting air conditioner turned up and felt like he was abruptly handled. Stated that	F 607	3. All staff of the facility will be provided with education by the DON on the facility abuse and neglect policy that includes types of abuse and protection of residents from abuse. This will include timely reporting of abuse in accordance with the facility policy and the Elder Justice Act. **4.** The facility administrator will audit grievances weekly for 4 weeks and then monthly for 2 months to ensure that no grievances that were filed meet the criteria for an allegation of abuse or neglect. The administrator or designee will audit any residents identified as having limited or supervised access weekly for 4 weeks and then monthly for 2 months to ensure protection is provided as plan of care. Results of audits will be submitted monthly to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 12/5/23	

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F 607	Continued From page 34 aid told him if he puts his call light on, they will not answer it. Upset and smelled of urine. [dated 7/20/23]. "Resident was saturated and upset about getting a shower to be cleaned up. He is ok now. [dated 7/20/23] Resident given shower and is ok at this time. No issues after shower. [signed by unit manager & Social Worker dated 7/20/23] A review of the clinical record revealed there were no progress notes for 07/20/2023 addressing this situation. On 10/19/2023 at approximately 2:00 p.m., an interview was conducted with Resident #54 who stated that on the day of the incident he was wanting the air conditioner turned up and the CNA told him if he rings the call bell, they will not answer it. When asked how that makes him feel he stated, "I hear stuff like that all the time around here." Resident #54 stated he was also in need of incontinence care, but the staff had failed to answer the call bell. He stated he ended up having to get a shower to get cleaned up because they waited so long to change him. He stated he complained to the Social Worker about it. Resident #54 was not able to recall who the staff member was that threatened to not answer the call bell. On 10/19/2023, an interview with the Social Worker was conducted, and he was not able to identify this issue as abuse or neglect; therefore, did not escalate it up to an abuse allegation. On 10/19/2023 at 6:28 p.m., an interview was conducted with the Administrator and Employee C (the Corporate Clinical Nurse Consultant). They	F 607		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 35 were asked if the Social Worker/Grievance Officer should be able to identify and report abuse and neglect. The Administrator stated all the staff should be able to identify and report abuse and neglect. The Administrator and Employee C were shown the grievance report from 07/20/2023 involving Resident #54, and agreed it was a threat to neglect the resident. When asked if this incident was investigated, the Administrator stated it had not been. When asked if this was reported to the appropriate offices, the Administrator stated it had not been. On 10/19/2023, a review of the facility's abuse policy revealed the following excerpts: Page 1 Paragraph 1: "Definitions: ABUSE is also the deprivation by an individual, including a caretaker, of good or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing." Page 3 Paragraph 4: "Identification": "B. Staff are encouraged to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member." On 10/19/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided. 2. For Resident #14, the facility staff failed to implement their abuse policy as evidenced by	F 607		

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	495235	A. BUILDING _____ B. WING _____	10/20/2023

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F 607	Continued From page 36 failure to protect the resident from a known perpetrator by allowing unrestricted/unsupervised visits between the resident and her known perpetrator. On 10/17/2023 in the afternoon, Resident #14 was visited in her room. During the interview/conversation, cognitive impairment and difficulty with memory recall was noted. The resident did acknowledge she had been to visit her daughter earlier in the day. Resident #14's daughter is also a resident of this facility. Resident #14 reported they can go and visit each other anytime they want. During the interview, observations were made of the resident's room, and revealed that Resident #14 had 2 blister packs of medication sitting on her bed and in a 3-drawer clear storage container there was a bottle of Tylenol and 2 cans of jock itch spray. Review of the facility's investigation documents revealed that on 2/3/23, there was an incident between Resident #14 and her daughter, Resident #55. The incident was witnessed by 2 staff members and involved Resident #55 being verbally abusive to Resident #14. The facility's investigation findings concluded, "The investigation showed that [Resident #55's name redacted] did verbally abuse her mother and upset her...APS [adult protective services], the physician and local police were notified." In conclusion, the facility stated, "The facility substantiated this verbal abuse due to the relationship of these two individuals it is tough to hold tight on interventions because of resident rights and the mother daughter relationship." In Resident #14's chart, there was a nursing progress note dated 06/23/2023, that read, "I was	F 607		

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F 607	Continued From page 37 called to the residents' room. Upon entering the residents' room, the resident expressed concerns about her daughter, she said she had not seen her for a couple days and was worried about her and asked if I could go check on her daughter for her. I received permission from the ADON [Assistant Director of Nursing] that the mother and daughter could have a supervised dinner in the dining area. The mother and daughter were supervised throughout the whole dinner. The daughter asked if she could help the mother find her Medicare card, permission was given, only the Medicare card was taken out of the wallet and given to the mother. The mother placed all her cards in her wallet and placed them in her purse. There was no personal contact noted during the dinner. The daughter left the dining room first then the mother was taken back to her room after the dinner." This progress note established that at some point the facility staff identified the necessity to supervise and restrict visits between Residents #14 and #55. On the afternoon of 10/19/2023, the Corporate Nursing Consultant advised Surveyor C that the Administrator had found 2 bottles of vodka in Resident #14's room and had to remove them. They felt Resident #14's daughter was providing/putting the items in Resident #14's room, to sabotage the survey. Throughout the survey, an abundance of over-the-counter medications were noted in Resident #14's room, which the facility staff also reported she was getting from her daughter, Resident #55. On 10/19/2023 during the end of day meeting, an interview was conducted with the facility Administrator, Director of Nursing, and Corporate Nursing Consultant. During the interview, the	F 607		

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F 607	Continued From page 38 survey team shared concerns with regards to Resident #55 providing Resident #14 with items that could be potentially harmful, to include the over-the-counter medication and vodka. The administration was asked what steps they were taking to protect Resident #14's safety. On the morning of 10/20/2023, the facility Administrator and Corporate Nursing Consultant reported to the survey team that Resident #14's room assignment had been moved directly across from the nursing station for closer monitoring and a staff member had been assigned to Resident as 1-on-1 to supervise any visits with Resident #55 and ensure that no items were given to Resident #14. On 10/20/2023, interviews were conducted with CNA B, LPN D, and LPN C, the unit manager. All three stated that prior to 10/20/2023, Residents #14 and #55 have been permitted to have unrestricted and unsupervised visits with each other ad lib [as they choose]. The facility policy titled, "Abuse," was reviewed. Excerpts from the policy read, ". 6. Protection: a. In the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident. b. The resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury or harm identified through assessment of the resident. " No further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations	F 609		

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F 609	Continued From page 39 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 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 interview, clinical record review, and facility documentation, the facility staff failed to report an allegation of abuse/neglect within 24 hours, if the events do not result in serious bodily injury, for 1 resident (Resident #54) in a survey sample of 39 residents.	F 609	1. Resident #54 incident from 7/20/23 was reported to VDH on 10/20/23. 2. All residents of the facility have the potential to be affected by this alleged deficient practice. An audit was conducted on all grievances filed in the past 90 days to ensure no other grievances filed should have been reported as an allegation of abuse. 3. All staff of the facility will be provided with education by the DON on the facility abuse and neglect policy that includes types of abuse and protection of residents from abuse. This will include timely reporting of abuse in accordance with the facility policy and the Elder Justice Act. 4. The facility administrator will audit grievances weekly to ensure that no grievances that were filed meet the criteria for an allegation of abuse or neglect. Results of weekly audits will be submitted monthly to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance.	12/5/2023

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F 609	Continued From page 40 The findings included: For Resident #54, the facility staff failed to identify, investigate, and report allegations of abuse to the Administrator. Resident #54 is a 92-year-old resident with diagnoses of, but not limited to, bradycardia, chronic kidney disease Stage 3, chronic obstructive pulmonary disease, history of falls, hypertension, muscle weakness, unsteady on feet, and muscle wasting and atrophy. On 10/17/2023, a review of the facility grievance log revealed that on 07/20/2023 Resident #54 was threatened by CNA who stated, "If you ring that call bell, I am NOT going to answer it." This grievance was written in the grievance book by the Social Worker (Employee F). A review of the complaint/grievance report read as follows: "Resident was wanting air conditioner turned up and felt like he was abruptly handled. Stated that aid told him if he puts his call light on, they will not answer it. Upset and smelled of urine. [dated 7/20/23]. Resident was saturated and upset about getting a shower to be cleaned up. He is ok now. [dated 7/20/23] Resident given shower and is ok at this time. No issues after shower. [signed by unit manager & Social Worker dated 7/20/23]." A review of the clinical record revealed there were no progress notes for 07/20/2023 addressing this situation. On 10/19/2023 at approximately 2:00 p.m., an	F 609	**5.** DOC- 12/5/23	

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F 609	Continued From page 41 interview was conducted with Resident #54 who stated that on the day of the incident he was wanting the air conditioner turned up, and the CNA told him if he rings the call bell, they will not answer it. When asked how that makes him feel, he stated, "I hear stuff like that all the time around here." Resident #54 stated he was also in need of incontinence care, but the staff had failed to answer the call bell. He stated he ended up having to get a shower to get cleaned up because they waited so long to change him. He stated he complained to the Social Worker about it. Resident #54 was not able to recall who the staff member was that threatened to not answer the call bell. On 10/19/2023, an interview with the Social Worker was conducted and he was not able to identify this issue as abuse or neglect; therefore, did not escalate it up to an abuse allegation. On 10/19/2023 at 6:28 p.m., an interview was conducted with the Administrator and Employee C (the Corporate Clinical Nurse Consultant). They were asked if the Social Worker/Grievance Officer should be able to identify and report abuse and neglect. The Administrator stated all the staff should be able to identify and report abuse and neglect. The Administrator and Employee C were shown the grievance report from 07/20/2023 involving Resident #54, and agreed it was a threat to neglect the resident. When asked if this incident was investigated, the Administrator stated it had not been. When asked if this was reported to the appropriate offices, the Administrator stated it had not been. On 10/20/2023, the Administrator submitted a copy of the Facility Reported Incident (FRI) that	F 609		

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F 609	Continued From page 42 was submitted to the OLC and other reporting agencies. A review of the facility Policy for abuse read as follows: Page 3 Paragraph 4 "Identification B. Staff are encouraged to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member." On 10/20/23 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	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	F 610	1. Resident #54 incident from 7/20/23 was reported to VDH on 10/20/23. 2. All residents of the facility have the potential to be affected by this alleged deficient practice. An audit was conducted on all grievances filed in the past 90 days to ensure no other grievances filed should have been reported as an allegation of abuse. Any identified will be reported and investigated.	12/5/2023

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F 610	Continued From page 43 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 interview, clinical record review, and facility documentation, the facility staff failed to investigate an allegation of abuse for 1 resident (Resident #54) in a survey sample of 39 residents. The findings included: For Resident #54, the facility staff failed to identify, report, and investigate an allegation of abuse made to the Social Worker on 07/20/2023. Resident #54 is a 92-year-old resident with diagnoses of, but not limited to, bradycardia, chronic kidney disease Stage 3, chronic obstructive pulmonary disease, history of falls, hypertension, muscle weakness, unsteady on feet, muscle wasting and atrophy. On 10/17/2023, a review of the facility grievance log revealed that on 07/20/2023, Resident #54 was threatened by CNA who stated, "If you ring that call bell, I am NOT going to answer it." This grievance was written in the grievance book by the Social Worker (Employee F). A review of the complaint/grievance report read as follows: "Resident was wanting air conditioner turned up and felt like he was abruptly handled. Stated that aid told him if he puts his call light on, they will not answer it. Upset and smelled of urine. [dated 7/20/23].	F 610	3. All staff of the facility will be provided with education by the DON on the facility abuse and neglect policy that includes types of abuse and protection of residents from abuse. This will include timely reporting of abuse in accordance with the facility policy and the Elder Justice Act. 4. The facility administrator will audit grievances weekly to ensure that no grievances that were filed meet the criteria for an allegation of abuse or neglect. Results of weekly audits will be submitted monthly to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 12/5/23	

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F 610	Continued From page 44 Resident was saturated and upset about getting a shower to be cleaned up. He is ok now. [dated 7/20/23] Resident given shower and is ok at this time. No issues after shower. [signed by unit manager & Social Worker dated 7/20/23]." A review of the clinical record revealed there were no progress notes for 07/20/2023 addressing this situation. On 10/19/2023 at approximately 2:00 p.m., an interview was conducted with Resident #54 who stated that on the day of the incident he was wanting the air conditioner turned up, and the CNA told him if he rings the call bell, they will not answer it. When asked how that makes him feel, he stated, "I hear stuff like that all the time around here." Resident #54 stated he was also in need of incontinence care, but the staff had failed to answer the call bell. He stated he ended up having to get a shower to get cleaned up because they waited so long to change him. He stated he complained to the Social Worker about it. Resident #54 was not able to recall who the staff member was that threatened to not answer the call bell. On 10/19/2023, an interview with the Social Worker was conducted and he was not able to identify this issue as abuse or neglect; therefore, did not escalate it up to an abuse allegation. On 10/19/2023 at 6:28 p.m., an interview was conducted with the Administrator and Employee C (the Corporate Clinical Nurse Consultant). They were asked if the Social Worker/Grievance Officer should be able to identify and report abuse and neglect. The Administrator stated all	F 610		

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F 610	Continued From page 45 the staff should be able to identify and report abuse and neglect. The Administrator and Employee C were shown the grievance report from 07/20/2023 involving Resident #54, and agreed it was a threat to neglect the resident. When asked if this incident was investigated, the Administrator stated it had not been. When asked if this was reported to the appropriate offices, the Administrator stated it had not been. On 10/20/2023, the Administrator submitted a copy of the Facility Reported Incident (FRI) that was submitted to the OLC and other reporting agencies. A review of the facility abuse policy revealed the following excerpts: Page 3 Paragraph 4 "Identification B. Staff are encouraged to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member." Page 3 Paragraph 5 "Investigation: Designated staff will immediately review and investigate all allegations or observations of abuse. a. The results of all investigations are to be communicated to the Administrator or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident and if the alleged violation is verified	F 610		

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F 610	Continued From page 46 appropriate corrective action must be taken." On 10/19/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 610		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636	1. Late MDS assessments were transmitted to CMS for Residents #1, #33, #36, #39, #68 and #274. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was conducted on all active residents of the facility and no other late assessments were noted. 3. The facility MDS coordinator will be provided education by the Regional MDS Nurse on the CMS regulation and the facility policy on transmission of MDS assessments timely.	12/5/2023

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F 636	Continued From page 47 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to complete resident assessments/Minimum Data Set (MDS) in a timely manner for 6 Residents (Residents #1, #33, #36, #39, #68 and #274) in a survey sample of 39 residents. The findings included:	F 636	4. An audit will be conducted weekly by the Regional MDS Nurse for transmission of assessments. Results of the weekly audits will be submitted to the NHA weekly. The NHA will report results of the weekly audits monthly to the QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	

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	495235	A. BUILDING _____ B. WING _____	10/20/2023

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F 636	Continued From page 48 1. For Residents #1, #33, #36, #39, #68 and #274, the facility staff failed to ensure the timely completion of MDS assessments. On 10/19/2023 at 8:50 a.m. during the completion of the survey process, clinical record reviews were conducted of Residents #1, #33, #36, #39, #68 and #274's MDS assessments with particular attention to the date(s) the assessments were completed. The following was noted: a. Resident #1 had a quarterly MDS with an Assessment Reference Date (ARD) of 08/27/2023. The assessment was completed on 09/11/2023. b. Resident #33 had a quarterly MDS with an ARD date of 09/08/2023. The assessment was completed on 09/30/2023. c. Resident #36 had a quarterly MDS with an ARD of 09/01/2023. The assessment was completed on 09/17/2023. d. Resident #39 had a quarterly MDS with an ARD of 08/22/2023. The assessment was completed on 09/06/2023. e. Resident #68 had a quarterly MDS with an ARD of 09/01/2023. The assessment was completed on 9/30/23. f. Resident #274, was admitted to the facility on 09/27/2023. He had an admission assessment with an ARD of 10/07/2023. The assessment was due to be completed by 10/10/2023, as of the date of survey, 10/19/2023, it had not been completed.	F 636		

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F 636	Continued From page 49 On 10/19/2023 at 10:34 a.m., an interview was conducted with the facility's MDS nurse/LPN H. LPN H was asked to explain the frequency and timing of MDS. LPN H said, "They all have dates and times they need to be done." When asked to explain the time frames and how she knows when they have to be completed and transmitted, LPN H stated, "The computer tells me." LPN H then showed Surveyor C in the electronic health record where dates are noted when assessments must be completed and transmitted. It was noted that some of the dates were in black text, some in red text, and some in green text. When asked what the different colors meant, LPN H was unsure. LPN H was asked about the transmission of MDS to CMS. LPN H said, "Transmitting to the state is actually done by my regional, I am an LPN so my RN has to sign for me, and normally the RN that signs for me is my regional. She signs and then will transmit. She will give me the ok to transmit." LPN H also stated, "We started the new things in Oct. [referring to the MDS changes that went into effect October 1, 2023] she is looking and paying attention to see what I am doing is correct. There are some things that haven't been transmitted because of that. I usually transmit on Fridays unless she tells me not to and she wants to check something. Prior to October, I transmit every Friday." During the above interview, the MDS Coordinator/LPN H was asked if she has a policy or document she follows that gives her direction and timeframes. LPN H said, "The RAI manual, it is like the bible of MDS." Also during the above conversation/interview with LPN H, the Corporate Nurse Consultant,	F 636		

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F 636	Continued From page 50 Employee C, joined Surveyor C and LPN H. Employee C confirmed the facility follows the RAI manual. Employee C was shown Resident #274's assessment, which was incomplete, and awaiting RN signature. Employee C confirmed the findings. The facility policy titled, "Electronic Transmission of the MDS," was reviewed. This policy read, "Specific Procedures/Guidance: 1. Staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS RAI Instruction Manual, before being permitted to use the MDS information system. An electronic copy of the MDS RAI Instruction Manual is maintained by the MDS coordinator..." The CMS "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, October 2023" was reviewed. On page 2-10 of the RAI Manual, it read, "...Assessment Timing refers to when and how often assessments must be conducted, based upon the resident's length of stay and the length of time between ARDs. The table in Section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the PPS assessment timing schedule is provided in Section 2.8. o For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary Team (IDT)." In the RAI manual, the table in Section 2.6 was referenced, and gave the following time frames	F 636		

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F 636	Continued From page 51 for completion of the MDS. "Quarterly assessments have an MDS Completion date No Later than: ARD + 14 calendar days... Admission assessments MDS completion Date is no later than 14th calendar day of the resident's admission (admission date +13 calendar days)." The previous version of the RAI manual, prior to the October 2023 revision, had the same requirements/dates for transmission of MDS. Therefore, there were no changes to the timing of MDS transmission to CMS with the revisions in October 2023. On 10/19/2023 during the end of day meeting, the facility Administrator, Director of Nursing, and corporate staff were made aware of the concerns regarding the facility not completing MDS timely. No further information was provided.	F 636		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days	F 640	1. Late MDS assessments were transmitted to CMS on 10/16/23 prior to the entrance of the survey team. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was conducted on all active residents of the facility and no other late assessments were noted.	12/5/2023

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F 640	Continued From page 52 after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to transmit resident assessments/Minimum Data Set (MDS) in a timely manner to Centers for Medicare & Medicaid Services (CMS) for 8 residents (Residents #1, #2, #33, #36, #39, #61,	F 640	3. The facility MDS coordinator will be provided education by the Regional MDS Nurse on the CMS regulation and the facility policy on transmission of MDS assessments timely. 4. An audit will be conducted weekly by the Regional MDS Nurse for transmission of assessments. Results of the weekly audits will be submitted to the NHA weekly. The NHA will report results of the weekly audits monthly to the QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	

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F 640	Continued From page 53 #63, and #68) in a survey sample of 39 residents. The findings included: 1. For Residents #1, #2, #33, #36, #39, #61, #63, and #68, the facility staff failed to transmit the MDS to the CMS system within the required timeframe of 14 days. On 10/19/2023 at 8:50 a.m. during the completion of the survey process, clinical record reviews were conducted of Residents #1, #2, #33, #36, #39, #61, #63, and #68's MDS assessments with particular attention to the date(s) they were transmitted to CMS. The following was noted: a. Resident #1 had a quarterly MDS with an Assessment Reference Date (ARD) of 08/27/2023, completed on 09/11/2023. This assessment was not transmitted to CMS until 10/16/2023. Review of the transmission batch report revealed this assessment had been rejected by the CMS system; therefore, it was still not accepted as being transmitted. b. Resident #2 had a quarterly MDS with an ARD of 09/13/2023, completed on 09/22/2023. This assessment was not transmitted to CMS until 10/16/2023, which exceeded the required 14 days from completion. c. Resident #33 had a quarterly MDS with an ARD date of 08/23/2023 completed on 09/06/2023. This assessment was not transmitted to CMS until 10/13/2023. The following assessments were transmitted to CMS late: quarterly assessment with an ARD of 09/08/2023 was completed on 09/30/2023. This assessment was not transmitted to CMS until 10/16/2023.	F 640		

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F 640	Continued From page 54 Another quarterly MDS with an ARD date of 09/22/2023 was completed on 9/30/23. This assessment was not transmitted to CMS until 10/16/2023. d. Resident #36 had a quarterly MDS with an ARD of 09/01/2023. This assessment was completed on 09/17/2023, and was not transmitted to CMS until 10/16/2023. e. Resident #39 had a Quarterly MDS with an ARD of 08/22/2023 and was completed on 09/06/2023. This assessment was not transmitted to CMS until 10/13/2023. The resident also had an annual MDS with an ARD of 09/08/2023. The assessment and care plan were completed on 09/17/2023. This assessment was not transmitted to CMS until 10/16/2023. f. Resident #61 had a "Discharge, Return Not Anticipated" assessment with an ARD of 09/08/2023. The assessment was completed on 09/08/2023 and was not transmitted to CMS until 10/13/2023. g. Resident #63 had a quarterly MDS with an ARD of 08/24/2023 completed on 09/06/2023. This assessment was not transmitted to CMS until 10/13/2023. h. Resident #68 had a quarterly MDS with an ARD of 09/01/2023. The assessment was completed on 09/30/2023 and was not transmitted to CMS until 10/16/2023. On 10/19/2023 at 10:34 a.m., an interview was conducted with the facility's MDS nurse/LPN H. LPN H was asked to explain the frequency and timing of MDS. LPN H said, "They all have dates	F 640		

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F 640	Continued From page 55	F 640		

and times they need to be done." When asked to explain the time frames and how she knows when they have to be completed and transmitted, LPN H stated, "The computer tells me." LPN H then showed Surveyor C in the electronic health record where dates are noted when assessments must be completed and transmitted. It was noted that some of the dates were in black text, some in red text, and some in green text. When asked what the different colors meant, LPN H was unsure. LPN H was asked about the transmission of MDS to CMS. LPN H said, "Transmitting to the state is actually done by my regional, I am an LPN so my RN has to sign for me, and normally the RN that signs for me is my regional. She signs and then will transmit. She will give me the ok to transmit." LPN H also stated, "We started the new things in Oct. [referring to the MDS changes that went into effect October 1, 2023] she is looking and paying attention to see what I am doing is correct. There are some things that haven't been transmitted because of that. I usually transmit on Fridays unless she tells me not to and she wants to check something. Prior to October, I transmit every Friday."

During the above interview the MDS Coordinator, LPN H, was asked if she has a policy or document she follows that gives her direction and timeframes. LPN H said, "The RAI manual, it is like the bible of MDS." LPN H was then asked to pull up several of the above residents, which included Resident #1, #33, and #36. LPN H was shown that the text in red meant that the MDS was completed or transmitted late. LPN H confirmed the findings.

Also during the above conversation/interview with LPN H, the Corporate Nurse Consultant,

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F 640	Continued From page 56	F 640		

Employee C, joined Surveyor C and LPN H. Employee C confirmed that MDS are to be transmitted within 14 days of completion. Employee C later in the morning approached Surveyor C and said he had spoken to the corporate MDS person, and found out they had some difficulty with the third-party vendor/system they use to transmit MDS around the beginning of October. Employee C was asked to provide any evidence and/or documentation of where they had communicated with the third-party vendor or CMS about the issues they were having. Nothing further was submitted.

The facility policy titled, "Electronic Transmission of the MDS," was reviewed. This policy read, "Specific Procedures/Guidance: 1. Staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS RAI Instruction Manual, before being permitted to use the MDS information system. An electronic copy of the MDS RAI Instruction Manual is maintained by the MDS coordinator..."

The facility policy titled, "MDS Completion and Submission Timeframes," was reviewed. This policy read, "The facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Specific Procedures/Guidance: 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident

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F 640	Continued From page 57 Assessment Instrument Manual..." The CMS "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, October 2023" was reviewed. On page 5-3 of the RAI Manual, it read, "...Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days) ..." The prior version of the RAI manual was reviewed and it noted the same requirements/dates for transmission of MDS. Therefore, there were no changes to the timing of MDS transmission to CMS with the revisions made in October 2023. On 10/19/2023 during the end of day meeting, the facility Administrator, Director of Nursing, and corporate staff were made aware of the concerns regarding the facility not transmitting MDS timely to CMS. No further information was provided.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 58 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656	1. Resident #125, #70, #21's care plans were revised to accurately reflect the care and services being provided to the resident. 2. All residents of the facility have the potential to be affected by this deficient practice. The MDS Coordinator will conduct an audit of Comprehensive care plans for all active residents to ensure that the care and services being provided are reflected on the resident's care plan. 3. IDT team members involved in the comprehensive care plan and Licensed nursing staff of the facility will be provided education by the DON on the facility policy for comprehensive care planning. 4. The DON or designee will perform and audit of 3 resident care plans weekly for accurate care planning. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	12/5/2023

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F 656	Continued From page 59 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement a comprehensive care plan for three residents (Residents #125, #70, and #21) in a survey sample of 39 Residents. The findings included: 1. For Resident #125, facility staff failed to implement and/or monitor for changes in behavior related to the use of psychotropic medications and/or dementia. On 10/17/2023 at 12:30 p.m., Resident #125 was observed in bed lying flat on his back. The resident was picking at the bed linens and pulling on his hospital gown repeatedly. The surveyor asked him if he needed help, and he replied in a stream of disjointed words in a rambling response.The surveyor asked Resident #125 his name, and other questions, the resident did not look up or respond to the surveyor. He simply kept picking at the gown, pulling it up, and attempting to disrobe. Review of the physician's orders in the clinical record revealed Resident #125 was currently receiving the following 3 psychotropic medications: 1. Buspar ER 100 mg (milligrams) ordered 09/28/2023, give every 12 hours at 9:00 a.m., and	F 656		

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F 656	Continued From page 60 9:00 p.m. for depression. 2. Seroquel 50 mg ordered 09/28/2023, give at 9:00 p.m. for anxiety. 3. Lexapro 20 mg ordered 10/12/2023, give at 9:00 a.m. for depression. On 10/18/23 after surveyor concerns were made known to the facility, the diagnosis for Seroquel was changed from "Anxiety" to "Dementia." Review of the Registered Pharmacist (RPH) medication regimen review (MRR) was conducted. The review revealed a recommendation document from the RPH on 10/11/2023 indicating that Resident #125 had no defined target behaviors and no behavior monitoring nor side effect monitoring forms for the Seroquel medication. It further stated that informed consent for psychotropic medication administration had not been obtained, which would be received from the resident's Power of Attorney (POA), as the resident was not able to be his own decision maker, and no behavior modification record or form had been started regarding non-pharmacologic interventions. Review of the current care plan dated 09/28/2023, revised 10/05/2023 upon discharge to the hospital, but not revised on 10/12/2023 upon return to the facility, revealed only 3 care planned problem areas that could be related to dementia. In the first two focuses there are options given beside a direction for staff to "SPECIFY" which is to be observed for the individual resident. None were highlighted as individualized for Resident #125. The 3 care plan entries read:	F 656		

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F 656	Continued From page 61 "1. FOCUS. The (name) resident uses psychotropic medications r/t (related to) depression. GOAL. The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment thru review date. Target date 12-27-23. INTERVENTIONS. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-shift (every shift). Consult with pharmacy, MD to consider dosage reductions when clinically appropriate at least quarterly. Monitor/record occurrence of for target behavior symptoms (SPECIFY: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/others. Etc.) and document per facility protocol. 2. FOCUS. The resident has impaired cognitive function/dementia or impaired thought processes. GOAL. The resident will remain oriented to (SPECIFY: person, place, situation, time) through the review date. Target date 12-27-23. INTERVENTIONS. Cue, reorient and supervise as needed. Monitor/document/report PRN (as needed) any changes in cognitive function, specifically changes in: decision making ability, memory, recall, and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status."	F 656		

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F 656	Continued From page 62 3. FOCUS. The resident has potential for psychosocial well-being problem. GOAL. The resident will have no indications of psychosocial well-being problem by/through review date. Target date 12-27-23. INTERVENTIONS. Monitor/document resident feelings relative to isolation, unhappiness, anger, loss)." On 10/17/2023 and 10/18/2023, Resident #125 was experiencing cognitive/behavioral impairment, was attempting to disrobe, and had inappropriate or absent responses to verbal communication. These behaviors were not monitored nor documented anywhere in the clinical record. There were no non-pharmacologic interventions care planned for this Resident, and the interventions were not individualized for this resident. On 10/12/2023 at 8:00 p.m., nursing notes indicated the resident was "Very confused... unscrewed bed remote...friend was going to come & pick him up shortly ...Resident unplugged IV machine...had female visitor who stated he was very confused, and she couldn't understand what he was talking about." Nursing indicated they were placing him on 1:1 for safety precautions. This was not care planned. On 10/18/2023 in an interview with the Social Worker, when asked what should be in a care plan for patients with dementia, he stated there should be non-pharmacological interventions for specific behaviors and activities specific to residents with dementia.	F 656		

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F 656	Continued From page 63 On 10/17/2023 and 10/18/2023 during the end of day debriefing, the Corporate RN, Administrator, and Director of Nursing (DON) were made aware of the findings. At the time of exit, they stated there was no further information available to submit to surveyors. 2. For Resident #70, facility staff failed to develop and implement a plan of care for limited range of motion of the right upper extremity. On 10/17/2023 at approximately 1:35 p.m., Resident #70 was observed lying quietly in bed. During the course of an initial interview with Resident #70, he demonstrated a limited range of motion with his right arm, in particular, his right shoulder. His right wrist appeared to be contracted as he was unable to move or rotate his wrist joint. Resident #70 was unable to speak due to a history of stroke but was able to nod "Yes" or "No" appropriately. On 10/18/2023 at approximately 2:00 p.m., Resident #70's clinical record was reviewed and included the following: *A progress note dated 05/25/2023, date of admission to the facility, which read in part, "...Patient does have right side weakness with verbal aphasia [inability to speak] due to a stroke...Pt [Patient] right arm is contracted and pt splint is to be worn when resting at night..." *A baseline nursing care plan dated 05/25/2023, page 7, Item I, "Neurological," Item 16, "LOC," Item 4, "Right Upper Extremity Movement/Grasps," had a check mark placed next to Item f, "Unable to Do."	F 656		

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F 656	Continued From page 64 *The current comprehensive care plan for Resident #70 did not address the limited range of motion to his right upper extremity. On 10/19/2023 at approximately 3:00 p.m., an interview was conducted with Employee E who stated she was responsible for the resident care plans. Employee E confirmed Resident #70's limited range of motion to his right arm. Employee E reviewed Resident #70's clinical record and current comprehensive care plan and stated, "There is nothing on the care plan about his right arm weakness and contractures, I have assessed him myself and I know he has impairments with his right arm at minimum. I'm not sure how we missed this, but his range of motion deficits should absolutely be part of his care plan, we need to make sure that we are doing all that we can, so it doesn't get any worse if possible." A facility policy was requested and received. Review of the facility policy entitled, "Care Planning--Comprehensive Person-Centered," page 3, item 13 read, "The comprehensive care plan will: (a) Incorporate identified problem areas...(g) Aid in preventing or reducing declines in the resident's functional status and/or functional levels...(i) Enhance the optimal functioning of the resident by focusing on a rehabilitative program..." On 10/19/2023 at the end of day meeting, the facility Administrator and Director of Nursing were updated on the findings. No further information was provided.	F 656		

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F 656	Continued From page 65 For Resident #21, the facility staff failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet the needs of the resident. On 10/20/2023, a review of the clinical record was conducted, and the following are excerpts from the care plan: "FOCUS: The resident has limited physical mobility AEB [As Evidenced By] Date Initiated: 05/03/202. INTERVENTION: AMBULATION: The resident requires assistance) by (X) staff to walk (SPECIFY FREQ) and as necessary. Date Initiated: 05/03/2023 Revision on 05/05/202." "FOCUS: The resident has (SPECIFY: URGE, STRESS, FUNCTIONAL, MIXED) bladder incontinence r/t [related to] Date Initiated: 05/03/2023." "FOCUS: o The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for pressure ulcer development r/t. Date Initiated: 05/03/2023." "FOCUS: The resident has (SPECIFY acute/chronic) pain r/t Date Initiated: 05/03/2023." "FOCUS: The resident has diabetic ulcer of the (SPECIFY location) r/t Date Initiated: 05/03/2023." On 10/20/2023 at 11:45 a.m., an interview was conducted with the DON, who was asked the	F 656		

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F 656	Continued From page 66 purpose of a care plan, and she stated that care plans tell staff what the care needs of the resident are. When asked if they should be tailored to the needs of each resident, and she stated they should. When asked if a care plan should be specific to that individual resident, she stated it should. The DON was shown the care plan, and asked if the care plan should have been filled in where it says (Specify), and she stated it should have been. When asked if this was a comprehensive care plan, she stated it was supposed to be. When asked if the resident was on an anti-coagulant, she stated she was. When asked if that should be care planned, she stated it should have been. On 10/20/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657	1. Resident #29s care plan has been updated to reflect current status. 2. All residents of the facility have the potential to be affected by this deficient practice. The MDS Coordinator will conduct an audit of Comprehensive care plans for all active residents to ensure that the care and services being provided are reflected on the resident's care plan.	12/5/2023

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F 657	Continued From page 67 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to review and revise the care plan for 1 resident (Resident #29) in a survey sample of 39 residents. The findings included: For Resident #29, the facility failed to update/review/revise the care plan with development of wounds. On 10/20/2023, a review of the care plan revealed the following excerpts: "FOCUS: The resident has potential for impairment to skin integrity r/t being quadriplegic. Date Initiated: 12/24/2022. Revision on: 07/27/2023 GOAL: The resident will maintain or develop clean and intact skin by the review date. Date Initiated: 12/24/2022. Revision on: 08/02/2023 Target Date: 10/22/23	F 657	3. IDT members involved in the development of the comprehensive care plan will be provided education by the DON on the facility policy for comprehensive care planning. 4. The DON or designee will perform and audit of 3 resident care plans weekly for accurate care planning. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	

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F 657	Continued From page 68 INTERVENTION: Encourage good nutrition and hydration to promote healthier skin. Date Initiated: 12/24/2022. Identify/document potential causative factors and eliminate/resolve where possible. Date Initiated: 12/24/2022. Keep skin clean and dry. Use lotion on dry skin. Date Initiated: 12/24/2022 Revision on: 12/24/2022. Resident refuses to have blood sugars checked at times. Date Initiated: 02/13/2023." On 10/20/2023 during clinical record review, it was found that Resident #29 developed a blister to the right thigh on 07/06/2023 that was not added to the care plan. The resident also developed a Stage II pressure area to the sacrum on 07/27/2023, and that area was also not added to the care plan. On 10/20/2023 at 11:45 a.m., an interview was conducted with the Director of Nursing (DON), who was asked the purpose of a care plan. She stated that care plans tell staff what the care needs of the residents are. When asked if they should be tailored to meet the needs of each resident, and she stated they should. When asked if a care plan should be specific to the individual resident, she stated it should. When asked how often the care plan should be updated, she stated quarterly and with changes in the resident's status. When asked if a new or reopened wound constitutes a change in the care plan, she stated it should be updated with wounds and anything that causes a change in the care of the resident. On 10/20/2023 during the end of day meeting, the Administrator was made aware of the concerns.	F 657		