STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. Building B. Wing	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide privacy and dignity for a Foley catheter for one of 25 residents in the survey, Resident #80. On 4/21/21, Resident #80 was observed lying in bed with an uncovered Foley catheter bag visible from the hall. The facility staff failed to provide privacy and dignity for the Foley catheter bag. The findings include: Resident #80 was admitted to the facility on [DATE]. Resident #80's diagnoses included but were not limited to chronic kidney disease, diabetes and paralysis. Resident #80's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/6/21, coded the resident's cognition as severely impaired. Section H coded the resident as having a urinary catheter. On 4/21/21 at 9:01 a.m. and 3:26 p.m., observations, Resident #80's bed room door was half way open. The resident was lying in bed with an uncovered Foley catheter (1) bag attached to the bed frame. The catheter bag and urine in the bag was visible from the hall. On 4/21/21 at 5:02 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a Foley catheter bag should be hooked on the bottom of the bed and should be covered in a bag for privacy. When asked how she would feel if her catheter bag was visible from the hall, LPN #3 stated, I don't want everybody to know. On 4/21/21 at 5:19 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated a Foley catheter bag should be in a privacy bag for dignity. When asked how she would feel if her catheter bag was visible from the hall, CNA #3 stated, Not too good. On 4/21/21 at 6:08 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility policy titled, CATHETER CARE: INDWELLING CATHETER documented in part, Catheter bags should be covered with a catheter dignity bag to preserve the dignity of the patient. No further information was presented prior to exit. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (1) A Foley catheter is a tube placed in the bladder that drains urine from the bladder into a bag outside of the body. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain a clean environment for one of 25 current residents in the survey sample, (Resident #25). The facility staff failed to clean Resident #25's feeding tube pump. The findings include: Resident #25 was admitted to the facility on [DATE], with diagnoses including but not limited to: epilepsy, COPD (chronic obstructive pulmonary disease) (1), and diabetes (2). The most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 2/16/21, coded Resident #25 as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). He was coded as being totally dependent on the assistance of staff members for all activities of daily living (ADL). He was coded as receiving feedings by way of a PEG (percutaneous endoscopic gastrostomy) (3) tube. Resident #25 declined to be interviewed during the survey. On the following dates and times, Resident #25 was observed lying on his back in bed. During all observations, Resident #25 was receiving PEG tube feeding with the use of a pump to provide the prescribed amount of feeding. On 4/20/21 at 11:40 a.m., 4/20/21 at 12:47 p.m., 4/20/21 at 1:48 p.m., and 4/21/20 at 9:11 a.m., observations of Resident #25's feeding tube pump revealed it contained multiple spots of yellowish-brown, thick and sticky residual on the front of the pump. A review of Resident #25's clinical record revealed the following physician's order, dated 4/12/21: Enteral Feed Order One time a day for nutrition. Glucerna 1.5 60 mls (milliliters)/hour (per hour). A review of Resident #25's comprehensive care plan dated 2/22/21 revealed, in part: Need for feeding tube/potential for complications of feeding tube use. On 4/21/21 at 9:11 a.m., RN (registered nurse) #6, the unit manager, was accompanied to observe Resident #25's feeding tube pump. When asked if the feeding tube pump was clean, RN #6 looked all over the pump, and then stated, I'm not sure. When asked about the multiple yellowish-brown, thick, sticky spots observed on the front of the pump, RN #2 stated, It just looks like some of the feeding dripped on it. Oh well, I can go clean it. On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she takes care of Resident #25 regularly, she stated she does. When asked if she had noticed Resident #25's feeding tube pump, LPN #2 stated, To be honest, I looked at it to make sure it was the right rate, and I just kept moving. She stated she had been told that the pump was dirty with feeding residual. LPN #2 stated it is not at all okay for a feeding tube pump to be dirty in this manner. On 4/22/21 at 5:17 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Tube Feedings: Feedings, revealed, in part: Completion of Procedure: Return equipment to designated area and clean/dispose as indicated. No further information was provided prior to exit. (1) COPD is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and [NAME], page 124. (2) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (3) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the required information to the receiving facility for facility-initiated transfers of five of 25 sampled residents, (Residents #80, #11, #33, #60 and #55). The facility staff failed to provide evidence that all required information was provided to the hospital staff for facility initiated transfers of Resident #80 on 2/25/21, Resident #60's on 3/21/21, and failed to evidence the comprehensive care plan goals were provided to the receiving facility for facility initiated transfer of Resident #33 on 2/27/21, Resident #55 on 4/12/21, and Resident #11 on 1/17/21, and failed to ensure the physician documented the rationale for the Resident #11's transfer in the clinical record. The findings include: 1. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #80 was transferred to the hospital on 2/25/21. Resident #80 was admitted to the facility on [DATE]. Resident #80's diagnoses included but were not limited to chronic kidney disease, diabetes and paralysis. Resident #80's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/6/21, coded the resident's cognition as severely impaired. A note signed by the nurse practitioner on 2/25/21 documented, Patient is a [AGE] year old female being seen today per nursing request due to acute onset of large amounts of coffee ground vomitus. Patient is still vomiting during this visit . A nurse's note dated 2/25/21 documented, RP (Responsible party) made aware. Res. sent to (name of hospital) per np (nurse practitioner) and family request. Further review of Resident #80's clinical record failed to reveal documentation to evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff. On 4/22/21 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated a face sheet, copy of doctor's orders, labs [laboratory tests], doctor's notes, nurses' notes, a transfer form and the care plan should be provided to hospital staff when residents transfer to the hospital. When asked how staff evidences the information was provided to hospital staff, LPN #5 stated she was not 100 percent sure how to answer that but sometimes a little box on the transfer form will pop up. Resident #80's clinical record did not contain a transfer form for 2/25/21. On 4/22/21 at approximately 5:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility document titled, Focus on F622 documented, The facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health are institution or provider . No further information was presented prior to exit. 29125 2. The facility staff failed to evidence Resident #11's comprehensive care plan goals were provided to the receiving facility, for the residents transfer to the hospital on 1/17/21, and failed to ensure that the physician wrote a note regarding the need for the 1/17/21 hospitalization for Resident #11. Resident #11 was admitted to the facility on [DATE] with the diagnoses of but not limited to multiple sclerosis, dysphagia, chronic obstructive pulmonary disease (COPD), dementia, depression, anxiety disorder, hypothyroidism, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/27/21. Resident #11 was coded as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating which coded Resident #11 as requiring extensive assistance. A review of the clinical record revealed a nurse's note dated 1/17/21 at 5:08 PM that documented part, Resident was found on floor by CNA (Certified Nursing Assistant) at 12:45PM when aide entered the room to pass out the lunch trays. Aide came to nurses station and got writer. Upon entering room resident was found face down on the floor. Resident was lying on the left side of the bed by the a.c (air conditioner) unit. Writer asked resident was she okay and she stated i'm (sic) in pain. Writer asked resident what happened and resident stated I was having a muscle spasm. Resident was assited (sic) to her back by 4 staff members and injuries were noted. Resident had a laceration to the left side of her head and multiple bruises on her head, arms, and hands. Resident was assisted back to bed with mechanical lift and 2 staff members. On call NP (nurse practitioner) notified at 12:50PM and gave order to transfer resident to (name of hospital). Residents daughter (name) notified at 1:00PM via telephone conversation of transfer. Resident left facility at 1:30AM by stretcher accompanied by paramedics. A nurse's note dated 1/19/21 at 3:01 PM documented, UM (unit manager) received a call from (name), daughter, with concerns about her mother's fall yesterday Resident was also admitted due to + (positive for) UTI (urinary tract infection) UM spoke with (name), SW (social worker) about above and (social worker) said that (daughter) is not the Legal Guardian Incident Report showed notification of (daughter) instead of Legal Guardian. UM called LG (legal guardian), (name), to inform of the fall on 1/17/21 and updated on (Resident #11) status as relayed by (daughter). He was appreciative of the call The resident was readmitted on [DATE]. Further review of the clinical record revealed an Acute Transfer Form dated 1/17/21 that provided demographic and medical information. This form did not evidence the comprehensive care plan goals were provided. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the clinical record failed to evidence that the physician wrote a note documenting the basis for the transfer, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). On 4/22/21 at 2:07 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). LPN #5 was asked what information is provided to the hospital staff. LPN #5 stated, We send the face sheet, copy of doctor's orders, labs [laboratory tests], doctor's notes, nurses notes, anything pertaining to what they would need for that instance, and a transfer form. The transfer form contains what hospital they are being sent to, their name, date of birth, medical reason for the transfer, vital signs, anything that needs to be on it. When asked if the comprehensive care plan goals are provided to the hospital, LPN #5 stated, Yes we do. When asked staff evidence they are provided, LPN #5 stated, I'm not 100% sure how to answer that. Sometimes it's a little box that will pop up on the transfer form about the care plan. When asked if nursing ensures the physician writes a note about the reason for transfer, LPN #5 stated, We can't control what the physician does. On 4/22/21 at 5:20 PM ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to evidence that Resident #33's comprehensive care plan goals were provided to the receiving facility upon transfer to the hospital on 2/27/21. Resident #33 was admitted to the facility on [DATE] with the diagnoses of but not limited to chronic obstructive pulmonary disease, atrial fibrillation, high blood pressure, and dementia. The most recent MDS (Minimum Data Set), an annual assessment with an ARD (Assessment Reference Date) of 3/1/21, coded Resident #33 as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 2/27/21 at 11:12 AM documented, X-Ray results to Right knee of Mildly impacted acute appearing right knee fracture MD (medical doctor) was called new order to send resident to E.R. (emergency room). RP (responsible party) called to up-date. A nurse's note dated 2/27/21 at 12:10 PM documented, Resident sent out to (name of hospital) on stretcher via EMS (emergency medical service) x 2 d/t (due to) fracture to RLE (right lower extremity) of unknown cause. Before transfer resident was assessed by this nurse, skin warm and dry to touch, no open areas noted at this time, VS (vital signs) witin (sic) normal limits. All ordered medicatons (sic) given to resident prior to transfer, no adverse reactions noted. No acute distress noted at time of transfer. RP/MD/Unit Manager (Responsible Party/Medical Doctor/Unit Manager) notified and updated on status. See previous notes. A nurse's note dated 2/27/21 documented, Resident returned to facility from (hospital) ED (emergency department) with a right knee immobilizer in place. Resident was seen at the ED for Avulsion fracture of tibial tuberosity, with instructions to follow up with (name of doctor), MD in 2 days around 3/1/2021. Specialty Orthopedic Surgery, (address and number) Radiology Results: Acute minimally displaced fracture of anterior tibial tubercle consistent with patellar tendon avulsion. No new orders from ED at this time (Physician) and family will be notified of resident's return to the facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the x-ray results dated 2/27/21 revealed, in addition to the injury itself, that the resident had osteopenia. A physician's progress note dated 3/3/21 documented, being seen today per nursing request due to right anterior tibial tubercle fracture that occurred on 2/27/21. X-ray report indicates presence of osteopenia. Patient being seen today due to risks that include pain, osteoporosis and repeated fractures. Patient is laying in bed during this exam, she denies pain at this time. Swelling noted to right knee with +1 edema to right ankle. Slight grimacing noted when RLE (right lower extremity) is moved. Currently using Tylenol and positioning for pain control. Denies any further concerns today. Further review of the clinical record revealed an Acute Transfer Form dated 2/27/21 that provided demographic and medical information. This form did not evidence that the comprehensive care plan goals were provided to the hospital at the time of Resident #33's transfer on 2/27/21. The resident was readmitted on the same day, 2/27/21, after an emergency roiagnom on ly visit. On 4/22/21 at 2:07 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). LPN #5 was asked what information is provided to the hospital staff. LPN #5 stated, We send the face sheet, copy of doctor's orders, labs [laboratory tests], doctor's notes, nurses notes, anything pertaining to what they would need for that instance, and a transfer form. The transfer form contains what hospital they are being sent to, their name, date of birth, medical reason for the transfer, vital signs, anything that needs to be on it. When asked if the comprehensive care plan goals are provided to the hospital, LPN #5 stated, Yes we do. When asked staff evidence they are provided, LPN #5 stated, I'm not 100% sure how to answer that. Sometimes it's a little box that will pop up on the transfer form about the care plan. On 4/22/21 at 5:20 PM ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. References: (1) Tylenol - is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html 4. The facility staff failed to evidence that all the required documentation was completed and/or provided to the receiving facility for Resident #60's hospital transfer on 3/21/21. Resident #60 was admitted to the facility on [DATE] with the diagnoses of but not limited to Moyamoya disease, quadriplegia, seizures, high blood pressure, chronic kidney disease, depression, cerebrovascular disease, and human immunodeficiency virus. The most recent MDS (Minimum Data Set) assessment, was a quarterly assessment with an ARD (Assessment Reference Date) of 3/29/21. Resident #60 was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating which required extensive assistance. A review of the clinical record revealed the following notes: (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note dated 3/24/21 at 8:04 PM documented, Resident transferred via stretcher and was readmit to the SNF (Skilled Nursing Facility) This note was upon return from the hospital and did not address the reason the resident was sent to the hospital on 3/21/21 and what documentation was sent. A Nurse Practitioner note 3/25/21 at 11:30 AM documented, .Medical Stability Visit with Medication Reconciliation at Transfer of Care & (and) Acute Physical Deconditioning (re)admitted to (facility) on 3/24/21 for rehabilitation with generalized weakness and unsteady gait S/P (status post) hospitalization for hematemesis. Admission records reveal pt (patient) was treated for cholelithiasis Patient's condition subsequently improved Additional Xrays not listed above - 3/22/21 ABD (abdominal) US (ultra sound) -FLUID FILLED GALL BLADDER WITH CHOLELITHIASIS Further review of the clinical record failed to reveal any evidence of pre-hospitalization nurse's notes documenting regarding the residents condition. Further review failed to evidence any hospital transfer documentation and paperwork that was completed and sent with the resident on transfer. On 4/23/21 at 10:07 AM ASM #1 (Administrative Staff Member, the Administrator) stated that the electronic health record system was down from 3/18/21 through 3/22/21. The resident was transferred to the hospital on 3/21/21. During this same meeting, ASM #3, the corporate Quality Consultant Nurse stated that no paper record documentation during the computer downtime could be located regarding this hospital transfer. ASM #3 also stated that there is an envelope with a checklist on the front that staff were supposed to use to compile all transfer documents in and maintain a copy of the completed checklist but that no one was following that procedure, so therefore, there was no documentation at all that evidenced what was going on with the resident, what the facility staff did for the resident, and what, if any, documents were prepared and provided to the hospital upon transfer. No further information was provided by the end of the survey. 42183 5. The facility staff failed to provide evidence that the comprehensive care plan goals were provided to the receiving hospital when Resident #55 was transferred to the hospital on 4/12/21. Resident #55 was admitted to the facility on [DATE]. Resident #55's diagnoses included but were not limited to: paraplegia (paralysis of the lower limbs) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and right below the knee amputation (surgical removal of part of the right leg below the knee) (3). Resident #55's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/17/20, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance in bed mobility, transfer, dressing, hygiene and bathing; walking and locomotion did not occur and independent in eating. During the initial resident observation on 4/20/21 at 10:35 AM, Resident #55 was not in room. On 4/20/21 at 11:55 AM, Resident #55 was not in her room and during lunch tray delivery a lunch tray not delivered. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/20/21 with CNA (certified nurse assistant) #1. When asked the location of Resident #55, CNA #1 stated, She went to the hospital last week, I believe it was on 4/12/21. A review of Resident #55's clinical record revealed a MDS, a discharge return anticipated assessment with an assessment reference date of 4/12/21. Further review of Resident #55's clinical record failed to reveal documentation to evidence that required information, comprehensive care plan goals were provided to the hospital staff for Resident #55's 4/12/21 transfer. In addition, there was no progress note describing transfer to the hospital, nor a physician order to transfer to the hospital. A physician order dated 4/22/21, documented in part, Admit to skilled nursing facility (SNF). On 4/22/20 at 5:15 PM, an interview was conducted with ASM (administrative staff member) #3, the quality consultant, regarding the above concern. ASM #1 stated she would look for any information. On 4/23/21 at 10:00 AM, ASM #3 stated, There is no further information any transfer documentation for Resident #55 for the 4/12/21 hospitalization . ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concerns on 4/23/21 at 10:20 AM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 432. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 29.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide written notification of transfer to residents and/or their representatives for five of 25 residents in the survey sample, (Residents #80, #11, #33, #60 and #55). The facility staff failed to evidence that written notification regarding the transfer was provided to the resident and/or representative for transfers to the hospital for: Resident #80, on 2/25/21, Resident #11, on 1/17/21, Resident #33, on 2/27/21, Resident #60, on 3/21/21 and Resident #55 on 4/12/21. The findings include: 1. Resident #80 was transferred to the hospital on 2/25/21. The facility staff failed to evidence that written notification regarding the transfer was provided to the resident and/or representative. Resident #80 was admitted to the facility on [DATE]. Resident #80's diagnoses included but were not limited to chronic kidney disease, diabetes and paralysis. Resident #80's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/6/21, coded the resident's cognition as severely impaired. A note signed by the nurse practitioner on 2/25/21 documented, Patient is a [AGE] year old female being seen today per nursing request due to acute onset of large amounts of coffee ground vomitus. Patient is still vomiting during this visit . A nurse's note dated 2/25/21 documented, RP (Responsible party) made aware. Res. sent to (name of hospital) per np (nurse practitioner) and family request. Further review of Resident #80's clinical record failed to reveal documentation to evidence the resident and/or representative was provided written notification regarding the transfer. On 4/22/21 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated nurses notify residents' representatives of hospital transfers via phone but do not provide any written notice. On 4/22/21 at 2:32 p.m., an interview was conducted with OSM (other staff member) #4 (the social worker). OSM #4 stated residents' representatives are notified of hospital transfers via phone and nursing sends a packet with residents to the hospital. On 4/22/21 at approximately 5:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility document titled, Focus on F623 documented, Before a facility transfer or discharges a resident, the facility must-- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. No further information was presented prior to exit. 29125 2. The facility staff failed to evidence that a written notification was provided to the resident and or resident representative upon Resident #11's transfer to the hospital on 1/17/21. Resident #11 was admitted to the facility on [DATE] with the diagnoses of but not limited to multiple sclerosis, dysphagia, chronic obstructive pulmonary disease (COPD), dementia, depression, anxiety disorder, hypothyroidism, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/27/21. The resident was coded as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating which coded the resident as requiring extensive assistance. A review of the clinical record revealed a nurse's note dated 1/17/21 at 5:08 PM that documented, Resident was found on floor by CNA (Certified Nursing Assistant) at 12:45PM when aide entered the room to pass out the lunch trays. Aide came to nurses station and got writer. Upon entering room resident was found face down on the floor. Resident was lying on the left side of the bed by the a.c (air conditioner) unit. Writer asked resident was she okay and she stated i'm in pain. Writer asked resident what happened and resident stated I was having a muscle spasm. Resident was assited to her back by 4 staff members and injuries were noted. Resident had a laceration to the left side of her head and multiple bruises on her head, arms, and hands. Resident was assisted back to bed with mechanical lift and 2 staff members. On call NP (nurse practitioner) notified at 12:50PM and gave order to transfer resident to (name of hospital). Residents daughter (name) notified at 1:00PM via telephone conversation of transfer. Resident left facility at 1:30AM by stretcher accompanied by paramedics. A nurse's note dated 1/19/21 at 3:01 PM documented, UM (unit manager) received a call from (name), daughter, with concerns about her mother's fall yesterday Resident was also admitted due to + (positive for) UTI (urinary tract infection) UM spoke with (name), SW (social worker) about above and (social worker) said that (daughter) is not the Legal Guardian Incident Report showed notification of (daughter) instead of Legal Guardian. UM called LG (legal guardian), (name), to inform of the fall on 1/17/21 and updated on (Resident #11) status as relayed by (daughter). He was appreciative of the call The resident was readmitted on [DATE]. Further review of the clinical record revealed an Acute Transfer Form dated 1/17/21 that provided demographic and medical information. There was no evidence on this form of written notification provided to the Resident Representative. Further review of the clinical record failed to reveal any evidence that a written notification of the transfer on 1/17/21, was provided to the Resident Representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/21 at 2:07 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). When asked if nursing provides any written notice of the transfer to the resident or Resident Representative, LPN #5 stated, No. On 4/22/21 at 2:33 PM, an interview was conducted with OSM #4 (Other Staff Member), the social worker. When asked if she has a role in providing written notification to Resident Representative, OSM #4 stated that she just calls them. On 4/22/21 at 5:20 PM ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to evidence that a written notification was provided to the resident and or the resident representative upon Resident #33's transfer to the hospital on 2/27/21. Resident #33 was admitted to the facility on [DATE] with the diagnoses of but not limited to chronic obstructive pulmonary disease, atrial fibrillation, high blood pressure, and dementia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/1/21. Resident #33 was coded as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 2/27/21 at 11:12 AM documented, X-Ray results to Right knee of Mildly impacted acute appearing right knee fracture MD (medical doctor) was called new order to send resident to E.R. (emergency room). RP (responsible party) called to up-date. A nurse's note dated 2/27/21 at 12:10 PM documented, Resident sent out to (name of hospital) on stretcher via EMS (emergency medical service) x 2 d/t (due to) fracture to RLE (right lower extremity) of unknown cause. Before transfer resident was assessed by this nurse, skin warm and dry to touch, no open areas noted at this time, VS (vital signs) witin (sic) normal limits. All ordered medicatons (sic) given to resident prior to transfer, no adverse reactions noted. No acute distress noted at time of transfer. RP/MD/Unit Manager (Responsible Party/Medical Doctor/Unit Manager) notified and updated on status. See previous notes. A nurse's note dated 2/27/21 documented, Resident returned to facility from (hospital) ED (emergency department) with a right knee immobilizer in place. Resident was seen at the ED for Avulsion fracture of tibial tuberosity, with instructions to follow up with (name of doctor), MD in 2 days around 3/1/2021. Specialty Orthopedic Surgery, (address and number) Radiology Results: Acute minimally displaced fracture of anterior tibial tubercle consistent with patellar tendon avulsion. No new orders from ED at this time (Physician) and family will be notified of resident's return to the facility. A review of the x-ray results dated 2/27/21 revealed, in addition to the injury itself, that the resident had osteopenia. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's progress note dated 3/3/21 documented, being seen today per nursing request due to right anterior tibial tubercle fracture that occurred on 2/27/21. X-ray report indicates presence of osteopenia. Patient being seen today due to risks that include pain, osteoporosis and repeated fractures. Patient is laying in bed during this exam, she denies pain at this time. Swelling noted to right knee with +1 edema to right ankle. Slight grimacing noted when RLE (right lower extremity) is moved. Currently using Tylenol and positioning for pain control. Denies any further concerns today. The resident was readmitted on the same day, 2/27/21, after an emergency roiagnom on ly visit. Further review of the clinical record revealed an Acute Transfer Form dated 2/27/21 that provided demographic and medical information. There was no evidence on this form of written notification provided to the Resident Representative for Resident #33's transfer to the hospital. Further review of the clinical record failed to reveal any evidence that written notification was provided to the Resident Representative. On 4/22/21 at 2:07 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). When asked if nursing provides any written notice of the transfer to the resident or Resident Representative, LPN #5 stated, No. On 4/22/21 at 2:33 PM, an interview was conducted with OSM #4 (Other Staff Member), the social worker. When asked if she has a role in providing written notification to Resident Representative, OSM #4 stated that she just calls them. On 4/22/21 at 5:20 PM ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. References: (1) Tylenol - is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html 4. The facility staff failed to evidence that a written notification was provided to the resident and or resident representative upon a hospital transfer on 3/21/21 for Resident #60. Resident #60 was admitted to the facility on [DATE] with the diagnoses of but not limited to Moyamoya disease, quadriplegia, seizures, high blood pressure, chronic kidney disease, depression, cerebrovascular disease, and human immunodeficiency virus. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/29/21. The resident was coded as being cognitively intact in ability to make daily life decisions. Resident #60 was coded as requiring total care for all areas of activities of daily living, except for eating which coded the resident as requiring extensive assistance. A review of the clinical record revealed the following notes: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note dated 3/24/21 at 8:04 PM documented, Resident transferred via stretcher and was readmit to the SNF (Skilled Nursing Facility) This note was upon return from the hospital and did not address the reason the resident was sent to the hospital on 3/21/21 and what documentation was sent. A Nurse Practitioner note 3/25/21 at 11:30 AM documented, .Medical Stability Visit with Medication Reconciliation at Transfer of Care & (and) Acute Physical Deconditioning (re)admitted to (facility) on 3/24/21 for rehabilitation with generalized weakness and unsteady gait S/P (status post) hospitalization for hematemesis. Admission records reveal pt (patient) was treated for cholelithiasis Patient's condition subsequently improved Additional Xrays not listed above - 3/22/21 ABD (abdominal) US (ultra sound) -FLUID FILLED GALL BLADDER WITH CHOLELITHIASIS Further review of the clinical record failed to reveal any evidence that written notification was provided to the Resident Representative for Resident #60's recent hospital transfer. On 4/22/21 at 2:07 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). When asked if nursing provides any written notice of the transfer to the resident or Resident Representative, LPN #5 stated, No. On 4/22/21 at 2:33 PM, an interview was conducted with OSM #4 (Other Staff Member), the social worker. When asked if she has a role in providing written notification to Resident Representative, OSM #4 stated that she just calls them. On 4/22/21 at 5:20 PM ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. 42183 5. The facility staff failed to provide evidence that notification was provided to the resident and or the resident representative and ombudsman upon Resident #55's transfer to the hospital on 4/12/21. Resident #55 was admitted to the facility on [DATE]. Resident #55's diagnoses included but were not limited to: paraplegia (paralysis of the lower limbs) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and right below the knee amputation (surgical removal of part of the right leg below the knee) (3). Resident #55's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/17/20, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance in bed mobility, transfer, dressing, hygiene and bathing; walking and locomotion did not occur and independent in eating. During the initial resident observation on 4/20/21 at 10:35 AM, Resident #55 was not in room. On 4/20/21 at 11:55 AM, Resident #55 was not in her room and during lunch tray delivery a lunch tray not delivered. An interview was conducted on 4/20/21 with CNA (certified nurse assistant) #1. When asked the location of Resident #55, CNA #1 stated, She went to the hospital last week, I believe it was on 4/12/21. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #55's clinical record revealed a MDS, a discharge return anticipated assessment with an assessment reference date of 4/12/21. Further review of Resident #55's clinical record failed to reveal documentation to evidence that all required information, resident and or responsible person notification, ombudsman notification were provided as soon as practicable before transfer or discharge. In addition, there was no progress note describing transfer to the hospital, nor a physician order to transfer to the hospital. A physician order dated 4/22/21, documented in part, Admit to skilled nursing facility (SNF). On 4/22/21 at 8:37 AM, an interview was conducted with RN (registered nurse) #3. When asked if the bed hold is documented, RN #3 stated, It should be documented and in the medical record. On 4/22/20 at 5:15 PM, an interview was conducted with ASM (administrative staff member) #3, the quality consultant. When asked if a written notice is provided for the bed hold upon transfer to the hospital, ASM #1 stated, Our internal process is to document it. We have a folder that they put all the transfer information in. I will look for the paper copies and have for you in the morning. On 4/23/21 at 10:00 AM, ASM #3 stated, There is no further information regarding any transfer documentation for Resident #55 for the 4/12/21 hospitalization . ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concerns on 4/23/21 at 10:20 AM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 432. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 29.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, and facility document review, it was determined that the facility staff failed to orient a resident prior to transfer for one of 25 current residents reviewed, Resident #55. The facility staff failed to provide evidence that all required information including the resident notification and orientation prior to transfer was provided to Resident #55 upon transfer to the hospital on 4/12/21. The findings include: Resident #55 was admitted to the facility on [DATE]. Resident #55's diagnoses included but were not limited to: paraplegia (paralysis of the lower limbs) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and right below the knee amputation (surgical removal of part of the right leg below the knee) (3). Resident #55's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/17/20, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance in bed mobility, transfer, dressing, hygiene and bathing. During the initial resident observation on 4/20/21 at 10:35 AM, Resident #55 was not in room. On 4/20/21 at 11:55 AM, Resident #55 was not in her room and during lunch tray delivery a lunch tray not delivered. An interview was conducted on 4/20/21 with CNA (certified nurse assistant) #1. When asked the location of Resident #55, CNA #1 stated, She went to the hospital last week, I believe it was on 4/12/21. A review of Resident #55's clinical record revealed a MDS, a discharge return anticipated assessment with an assessment reference date of 4/12/21. Further review of Resident #55's clinical record failed to reveal documentation to evidence that all required information the resident notification and orientation prior to transfer was provided to Resident #55 upon transfer to the hospital on 4/12/21. In addition, there was no progress note describing transfer to the hospital, nor a physician order to transfer to the hospital. A physician order dated 4/22/21, documented in part, Admit to skilled nursing facility (SNF). On 4/22/21 at 8:37 AM, an interview was conducted with RN (registered nurse) #3. When asked if a written notification and orientation is provided to the resident prior to transfer to the hospital, RN #3 stated, It should be documented and in the medical record. On 4/22/20 at 5:15 PM, an interview was conducted with ASM (administrative staff member) #3, the quality consultant. When asked if a written notification and orientation is provided to the resident prior to transfer to the hospital, ASM #1 stated, Our internal process is to document it. We have a folder that they put all the transfer information in. I will look for the paper copies and have for you in the morning. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/21 at 10:00 AM, ASM #3 stated, There is no further information regarding any transfer documentation for Resident #55 for the 4/12/21 hospitalization . ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concerns on 4/23/21 at 10:20 AM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 432. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 29.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a written bed hold notice for a facility-initiated transfer for four of 25 residents in the survey sample, (Residents #80, #11, #60 and #55). The facility staff failed to provide the resident and or the resident's representative written notification of the bed hold policy upon transfer to the hospital for: Resident #80's hospital transfer on 2/25/21, Resident #11's hospital transfer on 1/17/21, Resident #60's hospital transfer on 3/21/21, and Resident #55 upon transfer to the hospital on 4/12/21. The findings include: 1. The facility staff failed to provide Resident #80 and/or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 2/25/21. Resident #80 was admitted to the facility on [DATE]. Resident #80's diagnoses included but were not limited to chronic kidney disease, diabetes and paralysis. Resident #80's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/6/21, coded the resident's cognition as severely impaired. A note signed by the nurse practitioner on 2/25/21 documented, Patient is a [AGE] year old female being seen today per nursing request due to acute onset of large amounts of coffee ground vomitus. Patient is still vomiting during this visit . A nurse's note dated 2/25/21 documented, RP (Responsible party) made aware. Res. (resident) sent to (name of hospital) per np (nurse practitioner) and family request. Further review of Resident #80's clinical record failed to reveal evidence that written notification of the bed hold policy was provided to the resident and/or the resident representative. On 4/22/21 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated nurses are supposed to send a copy of the facility bed hold policy with residents when they are transferred to the hospital. LPN #5 stated nurses should document a note that the bed hold policy was provided but not all nurses do this. On 4/22/21 at approximately 5:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility document titled, Focus of F625 documented, Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was presented prior to exit. 29125 2. The facility staff failed to evidence that a written bed hold policy was provided to the Resident or Resident Representative for Resident #11's hospital transfer on 1/17/21. Resident #11 was admitted to the facility on [DATE], with the diagnoses of but not limited to multiple sclerosis, dysphagia, chronic obstructive pulmonary disease (COPD), dementia, depression, anxiety disorder, hypothyroidism, and high blood pressure. The most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 1/27/21, coded the resident as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating which coded the resident as requiring extensive assistance. A review of the clinical record revealed a nurse's note dated 1/17/21 at 5:08 PM, documented in part: . On call NP (nurse practitioner) notified at 12:50PM and gave order to transfer resident to (name of hospital). Residents daughter (name) notified at 1:00PM via telephone conversation of transfer. Resident left facility at 1:30AM by stretcher accompanied by paramedics. A nurse's note dated 1/19/21 at 3:01 PM documented, UM (unit manager) received a call from (name), daughter, with concerns about her mother's fall yesterday Resident was also admitted due to + (positive for) UTI (urinary tract infection) UM spoke with (name), SW (social worker) about above and (social worker) said that (daughter) is not the Legal Guardian Incident Report showed notification of (daughter) instead of Legal Guardian. UM called LG (legal guardian), (name), to inform of the fall on 1/17/21 and updated on (Resident #11) status as relayed by (daughter). He was appreciative of the call The resident was readmitted on [DATE]. Further review of the clinical record revealed an Acute Transfer Form dated 1/17/21 that provided demographic and medical information. This form did not include bed hold information. Further review of the clinical record failed to reveal any evidence that a written bed hold policy was provided to the Resident #11 and or the Resident Representative for the 1/17/21 hospital transfer. On 4/22/21 at 2:07 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). When asked if nursing provides the resident or Resident Representative a bed hold policy, LPN #5 stated, Yes. When asked how that is evidenced, LPN #5 stated, We send it with them. All that should be included in a note. When asked if the note should include everything that is sent, LPN #5 stated, You should but not everyone does. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/21 at 2:53 PM, an interview was conducted with OSM #3 (Other Staff Member), the Admissions Coordinator, regarding her role for a resident discharged to the hospital. OSM #3 stated, There are many times I will call the family to see if they want to pay to hold the bed. When asked if she provides the family with a written bed hold policy notice, OSM #3 stated, When they state they want to hold the bed or they don't want to hold the bed. They can do it verbally or they can sign. No evidence was provided that a written bedhold policy was provided. On 4/22/21 at 5:20 PM ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to evidence that a written bed hold policy was provided to the resident and or the Resident Representative for Resident #60's hospital transfer on 3/21/21. Resident #60 was admitted to the facility on [DATE] with the diagnoses of but not limited to Moyamoya disease, quadriplegia, seizures, high blood pressure, chronic kidney disease, depression, cerebrovascular disease, and human immunodeficiency virus. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/29/21. Resident #60 was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating which coded the resident as requiring extensive assistance. A review of the clinical record revealed the following notes: A nurse's note dated 3/24/21 at 8:04 PM documented, Resident transferred via stretcher and was readmit to the SNF (Skilled Nursing Facility) This note was upon return from the hospital and did not address the reason the resident was sent to the hospital on 3/21/21 and what documentation was sent. A Nurse Practitioner note 3/25/21 at 11:30 AM documented, .Medical Stability Visit with Medication Reconciliation at Transfer of Care & (and) Acute Physical Deconditioning (re)admitted to (facility) on 3/24/21 for rehabilitation with generalized weakness and unsteady gait S/P (status post) hospitalization for hematemesis. Admission records reveal pt (patient) was treated for cholelithiasis Patient's condition subsequently improved Additional Xrays not listed above - 3/22/21 ABD (abdominal) US (ultra sound) -FLUID FILLED GALL BLADDER WITH CHOLELITHIASIS Further review of the clinical record failed to reveal any evidence that a written bed hold policy was provided to the resident and or the Resident Representative for Resident #60's recent hospital transfer. On 4/22/21 at 2:07 PM an interview was conducted with LPN #5 (Licensed Practical Nurse). When asked if nursing provides the resident or Resident Representative a bed hold policy, LPN #5 stated, Yes. When asked how that is evidenced, LPN #5 stated, We send it with them. All that should be included in a note. When asked if the note should include everything that is sent, LPN #5 stated, You should but not everyone does. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/21 at 2:53 PM, an interview was conducted with OSM #3 (Other Staff Member), the Admissions Coordinator, regarding her role for a resident discharged to the hospital. OSM #3 stated, There are many times I will call the family to see if they want to pay to hold the bed. When asked if she provides the family with a written bed hold policy notice, OSM #3 stated, When they state they want to hold the bed or they don't want to hold the bed. They can do it verbally or they can sign. No evidence was provided that a written bedhold policy was provided. On 4/22/21 at 5:20 PM ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. 42183 4. The facility staff failed to provide evidence that the bed hold information was provided to Resident #55 upon transfer to the hospital on 4/12/21. Resident #55 was admitted to the facility on [DATE]. Resident #55's diagnoses included but were not limited to: paraplegia (paralysis of the lower limbs) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and right below the knee amputation (surgical removal of part of the right leg below the knee) (3). Resident #55's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/17/20, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance in bed mobility, transfer, dressing, hygiene and bathing; walking and locomotion did not occur and independent in eating. During the initial resident observation on 4/20/21 at 10:35 AM, Resident #55 was not in room. On 4/20/21 at 11:55 AM, Resident #55 was not in her room and during lunch tray delivery a lunch tray not delivered. An interview was conducted on 4/20/21 with CNA (certified nurse assistant) #1. When asked the location of Resident #55, CNA #1 stated, She went to the hospital last week, I believe it was on 4/12/21. A review of Resident #55's clinical record revealed a MDS, a discharge return anticipated assessment with an assessment reference date of 4/12/21. Further review of Resident #55's clinical record failed to reveal documentation to evidence that bed hold information was provided at the time of transfer or discharge. In addition, there was no progress note describing transfer to the hospital, nor a physician order to transfer to the hospital. A physician order dated 4/22/21, documented in part, Admit to skilled nursing facility (SNF). On 4/22/21 at 8:37 AM, an interview was conducted with RN (registered nurse) #3. When asked if the bed hold is documented, RN #3 stated, It should be documented and in the medical record. On 4/22/20 at 5:15 PM, an interview was conducted with ASM (administrative staff member) #3, the quality consultant. When asked if a written notice is provided for the bed hold upon transfer to the hospital, ASM #1 stated, Our internal process is to document it. We have a folder that they put all the transfer information in. I will look for the paper copies and have for you in the morning. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/21 at 10:00 AM, ASM #3 stated, There is no further information regarding bed hold or any transfer documentation for Resident #55 for the 4/12/21 hospitalization . ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concerns on 4/23/21 at 10:20 AM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 432. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 160. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 29.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview and facility document review, it was determined the facility staff failed to develop a baseline care plan for one of 25 current residents in the survey sample, Resident #24. The facility failed to develop a baseline care plan for Resident #24 to address the care required for the resident's tracheostomy and failed to address ROM (range of motion), which was triggered on the 2/6/21, admission assessment for the baseline care plan. The findings include: Resident #24 was admitted to the facility on [DATE]. Resident #24's diagnoses included but were not limited to: anoxic brain injury (irreversible damage to the brain caused by a lack of oxygen) (1), seizures (a sudden, involuntary and violent contraction of a group of muscles, sometimes with loss of consciousness) (2) and tracheostomy (a surgically created opening into the trachea, with a tube inserted to establish an airway) (3). Resident #24's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/13/21, coded the resident as scoring 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. Section G-Functional Status: coded the resident as dependent with bed mobility, transfers, dressing, eating, personal hygiene and bathing; walking and locomotion did not occur. A review of MDS Section O- Special treatments, procedures and programs: coded the resident as tracheostomy 'yes' and oxygen therapy 'yes'. A review of the physician orders dated 2/6/21, documents in part, Suction as needed to maintain patent airway and every shift. Trach (tracheostomy) care daily and as needed. Remove disposable and dispose of inner cannula. Replace with new inner cannula as needed to reduce the risk of infection. A review of Resident #24's baseline care plan dated 2/6/21 failed to evidence documentation of tracheostomy care. Baseline care plan, documents in part, FOCUS-The resident has altered respiratory status/difficulty breathing related to tracheostomy status. INTERVENTIONS-Administer medications as ordered elevate head of bed 30 degrees, monitor changes in orientation, anxiety and air hunger. Monitor for signs and symptoms of respiratory distress and report to physician. Monitor and report abnormal breathing patterns to physician. Position resident with proper body alignment for optimal breathing pattern. Range of Motion was not identified as a focus on the baseline care plan provided. A review of the admission evaluation dated 2/6/21, documented in part, Clinical evaluation-neurological: identify areas of weakness- right upper extremity, left upper extremity, right lower extremity, left lower extremity (all four areas were checked). Clinical evaluation-musculoskeletal: upper extremity range of motion- impairment on both sides, lower extremity range of motion-impairment on both sides. Trigger for baseline care plan: Alteration in musculoskeletal status. The resident's mobility will be improved/restored by use of (specify: prosthesis, use of adaptive equipment). Trigger for baseline care plan was not included on baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the medical practitioner full assessment dated [DATE], documented in part, Musculoskeletal decreased ROM and weakness-atrophy or spasticity were checked. Abnormal findings documented-contracture of right hand. An interview was conducted on 4/21/21 at 8:53 AM with LPN (licensed practical nurse) #1, regarding the purpose of the baseline care plan. LPN #1 stated, The base line care plan is the initial plan of care for the resident based on physician orders and initial assessment. It gives us the interventions we need for the resident. An interview was conducted on 4/21/21 at 11:53 AM with ASM (administrative staff member) #3, the quality consultant. When asked who completes the baseline care plan, ASM #3 stated, The baseline care plan is completed by the admissions nurse. When asked who provides revisions to the care plan, ASM #3 stated, The IDT (inter-disciplinary team) or anyone who finds a change should revise the care plan. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concern on 4/21/21 at 5:40 PM. The facility's Interdisciplinary Care Planning policy dated 3/2018, documents in part, A baseline care plan must include the minimum healthcare information necessary to properly care for a patient including, but not limited to: Initial goals based on admission orders, physician orders, therapy services, social services and dietary orders. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 37. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 137. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 574.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and/or implement a comprehensive care plan for eight of 25 residents in the survey sample, (Residents #61, #25, #67, #24, #44, #35, #3 and #11). The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident # 61, #3 and #11; for Resident #25, the facility (a) failed to develop a comprehensive care plan to address his urinary catheter and (b) failed to implement his care plan for a tracheostomy; for Resident #67, the facility staff failed to implement the comprehensive care plan for (a) dialysis services and (b) toenail care; and the facility staff failed to implement the comprehensive care plan for care and services of a tracheostomy for Resident #44 and #35, and Resident #24. The findings include: 1. The facility staff failed to implement Resident #61's comprehensive care plan for oxygen administration. Resident #61 was admitted to the facility on [DATE]. Resident #61's diagnoses included but were not limited to chronic obstructive pulmonary disease (lung disease), congestive heart failure and sleep apnea (2). Resident #61's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/30/21, coded the resident as being cognitively intact. Section G coded Resident #61 as requiring extensive assistance of two or more staff with bed mobility. Review of Resident #61's clinical record revealed a physician's order dated 3/24/21 for oxygen at three liters continuously via nasal cannula every day shift and every evening shift. Resident #61's comprehensive care plan dated 4/5/21 documented, Has/At risk for respiratory impairment related to COPD (chronic obstructive pulmonary disease), sleep apnea. Administer medications/treatments per physician orders . On 4/20/21 at 11:35 a.m. and 4/20/21 at 2:05 p.m., Resident #61 was observed lying in bed receiving oxygen via nasal cannula connected to an oxygen concentrator that was running. Observation of the oxygen concentrator flowmeter revealed it was set at a rate between three and a half and four liters as evidenced by the center of the ball in the concentrator flow meter positioned between the three and a half and four liter lines. On 4/21/21 at 5:02 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for three liters of oxygen. LPN #3 stated the middle of the ball in the flow meter should be on the three liter line. In regards to the purpose of a care plan, LPN #3 stated a care plan is used to inform every one of expected treatments during a resident's stay. LPN #3 stated she periodically looks at care plans and also updates them when any changes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/21 at 6:10 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility policy regarding interdisciplinary care planning documented, The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive. Once the care plan is developed, the staff must implement the interventions identified in the care plan . No further information was presented prior to exit. 32642 2. For Resident #25, the facility (a) failed to develop a comprehensive care plan to address his urinary catheter and (b) failed to implement his care plan for a tracheostomy. a. Resident #25 was admitted to the facility on [DATE] with diagnoses including epilepsy, COPD (chronic obstructive pulmonary disease) (1), and diabetes (2). The most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/16/21, coded Resident #25 as moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). Resident #25 was coded as being totally dependent on the assistance of staff members for all activities of daily living. He was coded as having a Foley catheter (3) in place. Resident #25 declined to be interviewed during the survey. On 4/20/21 at 11:40 a.m., 4/20/21 at 12:47 p.m., 4/20/21 at 1:48 p.m., and 4/21/20 at 9:11 a.m., observation revealed Resident #25 lying on his back in bed. During each observation, a Foley catheter collection bag, contained in a privacy cover, was hanging on the bed frame. Observation revealed the catheter was draining light yellow urine. A review of Resident #25's admission nursing assessment dated [DATE] revealed documentation confirming Resident #25 had a Foley catheter in place on admission. A review of Resident #25's physicians' orders revealed the following order, dated 3/4/21, that documented, Foley catheter care q (each) shift. A second physicians order for Resident #25 dated 3/6/21, documented, Foley output every shift for monitoring purpose. There was no order for urinary output monitoring prior to 3/6/21. Further review of Resident #25's clinical record revealed the following physician order, dated 3/24/21, Levofloxacin Tablet (5) 250 mg give one tablet via PEG (percutaneous endoscopic gastrostomy) tube (4) one time a day for UTI (urinary tract infection). A review of Resident #25's comprehensive care plan dated 2/22/21, failed to evidence any information related to the resident's Foley catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed regarding the purpose of a comprehensive care plan. LPN #2 stated it is to make sure that all a resident's needs are met, and that the outcomes are accomplished. When asked if a resident's urinary catheter should be included in the comprehensive care plan, she stated it should. On 4/21/21 at 3:08 p.m., CNA (certified nursing assistant) #3 was interviewed regarding the purpose of a resident's comprehensive care plan. CNA #3 stated it is to make sure all the needs of a resident are met. She added the staff should always be asking what they could do to improve. CNA #3 stated the staff should always be asking how the resident wants things done. On 4/21/21 at 6:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. On 4/22//21 at 1:41 p.m., LPN #5 was interviewed. She stated the purpose of a care plan is to make sure the things a resident needs to be cared for are all in place. No further information was provided prior to exit. REFERENCES (1) COPD is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and [NAME], page 124. (2) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (3) A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder. This information is taken from the website https://medlineplus.gov/ency/article/003981.htm. (4) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm (5) Levofloxacin (Levaquin) is used to treat certain infections such as pneumonia, and kidney, prostate (a male reproductive gland), and skin infections. Levofloxacin is also used to prevent anthrax (a serious infection that may be spread on purpose as part of a bioterror attack) in people who may have been exposed to anthrax germs in the air, and treat and prevent plague (a serious infection that may be spread on purpose as part of a bioterror attack. Levofloxacin may also be used to treat bronchitis, sinus infections, or urinary tract infections but should not be used for bronchitis and certain types of urinary tract infections if there are other treatment options available. Levofloxacin is in a class of antibiotics called fluoroquinolones. It works by killing bacteria that cause infections. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697040.html. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(b) The failed staff failed to implement Resident #25's comprehensive care plan for tracheostomy care. The clinical record failed to evidence tracheostomy (6) care was provided to Resident #25, from 2/9/21 through 3/3/21. On the following dates and times, 4/20/21 at 11:40 a.m., 4/20/21 at 12:47 p.m., 4/20/21 at 1:48 p.m., and 4/21/20 at 9:11 a.m., Resident #25 was observed lying on his back in bed. During each observation, Resident #25 was observed with a tracheostomy in place. A review of Resident #25's comprehensive care plan dated 2/22/21 revealed, in part: Has/At risk for respiratory impairment related to COPD, tracheostomy .Trach [tracheostomy] care per protocol. A review of Resident #25's admission nursing assessment dated [DATE] revealed documentation confirming Resident #25 had a tracheostomy in place on admission. A review of Resident #25's physicians' orders revealed the following order, dated 3/4/21: Trach (tracheostomy) care Q (every) shift, every shift. There was no physician's order for trach care prior to 3/4/21. A review of Resident #25's TARs (treatment administration records) revealed no evidence of trach care being administered by facility staff prior to 3/4/21. Further review of Resident #25's clinical record revealed no evidence of any respiratory infections since his admission to the facility on [DATE]. On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she takes care of Resident #25 regularly, she stated she does. When asked if it is important to provide trach care to the resident as ordered by the physician, LPN #5 stated it is. LPN #5 stated the trach care helps prevent the resident from getting a respiratory infection. She stated she provides trach care for the resident during every shift she works. When asked the purpose of a comprehensive care plan, LPN #5 stated it is to make sure that all a resident's needs are met, and that the outcomes are accomplished. On 4/22/21 at 2:07 p.m., LPN #5 was interviewed. When asked if a resident who is admitted with a trachesostomy should have orders for trachesostomy care, she stated yes. She stated the nurse who completes a resident's admission assessment is responsible for making certain there are orders for trach care. She stated if a resident does not receive trach care, they are at a high risk for developing a respiratory infection. On 4/22/21 at 5:17 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. No further information was provided prior to exit. REFERENCES (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(6) A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information is taken from the website https://medlineplus.gov/ency/article/002955.htm. 3. For Resident #67, the facility staff failed to implement the comprehensive care plan for (a) dialysis services and (b) toenail care. a. For Resident #67, the facility staff failed to maintain communication with the dialysis (1) center, failed to implement a fluid restriction, and failed to assess her dialysis access site per her comprehensive care plan. Resident #67 was admitted to the facility on [DATE], and most recently readmitted on [DATE], with diagnoses including ESRD (end stage renal disease) (2), diabetes (3), lymphedema (4), and bipolar disorder (5). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/12/21, Resident #67 was coded as having no cognitive impairment for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as receiving dialysis services. Resident #67 refused to be interviewed regarding dialysis. On the following dates and times, 4/20/21 at 11:38 a.m., 4/20/21 at 12:40 p.m., 4/20/21 at 1:45 p.m., 4/21/21 at 9:11 a.m., and 4/21/21 at 2:46 p.m., Resident #67 was observed lying on her back in the bed. A review of Resident #67's comprehensive care plan, dated 11/8/2020 and updated 4/1/21, revealed, in part: Renal insufficiencies related to chronic renal failure .Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines .Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis and as needed . Coordinate dialysis care with dialysis treatment center .Dialysis 3X (three times) per week, T, TH, SA (Tuesday, Thursday, Saturday), fluid restriction 1500 mls (milliliters)/24 hours (in 24 hours). A review of Resident #67's clinical record revealed a readmission nursing assessment dated [DATE]. On this assessment, Resident #67 was documented as requiring hemodialysis, and to have a right upper chest catheter as the hemodialysis access site. Further review of Resident #67's clinical record revealed progress notes documenting Resident #67's leaving the facility and receiving hemodialysis on the following dates: 2/19/21, 3/3/21, 3/15/21, 3/17/21, 4/2/21, 4/5/21, 4/7/21, and 4/19/21. Further review of Resident #67's clinical record failed to reveal a physician's order for hemodialysis, for assessment of her access site for bruit and thrill (6), or an order for fluid restriction after her readmission on 2/17/21. A review of Resident #67's MARs (medication administration record) and TARs (treatment administration records) since 2/17/21 revealed no evidence of dialysis services, including site assessment or fluid restriction. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #67 dialysis communication book revealed no evidence of any dialysis communication between the facility and dialysis center on 2/19/21, 3/3/21, 3/15/21, and 3/17/21. The dialysis communication book contained no communication from the dialysis center to the facility on [DATE] and 4/5/21. On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she takes care of Resident #67, she stated she does. When asked if Resident #67 receives dialysis, LPN #2 stated the resident does sometimes. She stated the resident is scheduled to go three times a week, but the resident is noncompliant, and frequently refuses to go to dialysis. LPN #2 stated the resident should have an order for assessment of her right upper chest port. When asked if Resident #67 is on a fluid restriction, LPN #2 stated, I thought so, but now I'm not so sure. She stated Resident #67 has problems with too much fluid and lymphedema, and she knows the resident was on a fluid restriction prior to being discharged from the facility and readmitted on [DATE]. LPN #2 stated the dialysis communication should always be filled out at the facility, then sent with the resident to dialysis. She stated the dialysis center should fill out their portion of the form, and return the communication book with the resident. LPN #2 stated this is important because, We want to know what they did to her. She stated if the dialysis book is returned to the facility with no information from the dialysis center, she would call the dialysis center and get a verbal report. When asked the purpose of a comprehensive care plan, LPN #2 stated it is to make sure that all a resident's needs are met, and that the outcomes are accomplished. On 4/21/21 at 3:08 p.m., CNA (certified nursing assistant) #3 was interviewed. When asked the purpose of a resident's comprehensive care plan, CNA #3 stated it is to make sure all the needs of a resident are met. She added the staff should always be asking what they could do to improve. She stated the staff should always be asking how the resident wants things done. On 4/21/21 at 6:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. On 4/22//21 at 1:41 p.m., LPN #5 was interviewed. She stated the purpose of a care plan is to make sure the things a resident needs to be cared for are all in place. On 4/23/21 at 10:08 a.m., ASM #3 confirmed the evidence that Resident #67's care plan for dialysis service was being followed did not exist. No further information was provided prior to exit. REFERENCES (1) When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week. This information was taken from the website https://medlineplus.gov/dialysis.html. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD). This information is taken from the website https://medlineplus.gov/ency/article/000500.htm. (3) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (4) Lymphedema (LE) is the accumulation of protein-rich fluid in tissues. The impaired function of lymph vessels interrupts the drainage of lymphatic system that is a part of the circulatory system just like the arterial and venous structures. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5508242/#:~:text=Lymphedema%20(LE)%20is%20the%20accumulation,the%20arterial%20and%20venous%20structures. (5) Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks. This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (6) Your access is your lifeline. You will need to protect your access. Wash the area around your access with soap and warm water every day. Check the area for signs of infection, such as warmth or redness. When blood is flowing through your access and your access is working well, you can feel a vibration over the area. Let your dialysis center know if you can't feel the vibration. This information is taken from the website https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis. b. The facility staff failed to implement Resident #67's care plan to trim her toenails to an optimal length to prevent infection and disease. Resident #67 refused to be interviewed regarding her toenails. On 4/21/21 at 2:46 p.m., observation was made of Resident #67's feet. The resident was lying on her back in the bed, and RN (registered nurse) #1 was assessing the resident's feet. RN #6 was assisting her. Resident #67's right great toenail was observed to be at least 1/2 inch beyond her nail bed, thick, with some black areas scattered over the nail. The right third and fourth toenails were at least 1/2 inch beyond the nail bed. The left great toenail and left third toenails were discolored, with some dark areas. The left fourth toenail was at least 1/2 inch beyond the nail bed. RN #6 stated, The nails are definitely too long. They need to be cut. I will have to call the podiatrist. RN #1 stated she thought the doctor needed to look at all the nails because of the nail discolorations on both feet. She stated there could be a fungal infection or some other process going on. She stated that the toenails were too long, and needed to be cut as soon as possible to promote foot health for Resident #67. A review of Resident #67's comprehensive care plan dated 11/24/20 revealed, in part: ADL (activities of daily living) self care deficit related to physical limitations .Will receive assistance necessary to meet ADL needs .2 staff assistance with ADLS .Assist with daily hygiene, grooming, dressing, oral care, and eating as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she takes care of Resident #67, she stated she does. When asked if she remembers assessing Resident #67's toenails recently, LPN #2 stated she could not remember. She stated the CNAs (certified nursing assistants) will tell her if a resident's toenails need attention. She stated there is a list on the unit for residents who need a podiatrist to see them. LPN #2 stated she does not think Resident #67 is on that list, but she could be added. When asked if discoloration of a resident's toenails means anything significant, she stated it could simply mean the toenails need to be cleaned, or it could mean that the resident has some sort of infection. On 4/21/21 at 3:08 p.m., CNA #3 was interviewed. She stated she frequently works with Resident #67, and she looks at the resident's toenails every time I take care of her and bathe her. She stated she tries to give the resident a bath every day. She stated if she noticed the resident's toenails getting too long, she would tell the nurse. On 4/21/21 at 6:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. No further information was provided prior to exit. 42183 4. The facility failed to develop a comprehensive care plan to include trach [tracheostomy] care and ROM (range of motion) for Resident #24. Resident #24 was admitted to the facility on [DATE]. Resident #24's diagnoses included but were not limited to: anoxic brain injury (irreversible damage to the brain caused by a lack of oxygen) (1), seizures (a sudden, involuntary and violent contraction of a group of muscles, sometimes with loss of consciousness) (2) and tracheostomy (a surgically created opening into the trachea, with a tube inserted to establish an airway) (3). Resident #24's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/13/21, coded the resident as scoring 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G-Functional Status: coded the resident as dependent with bed mobility, transfers, dressing, eating, personal hygiene and bathing; walking and locomotion did not occur. A review of MDS Section O- Special treatments, procedures and programs: coded the resident as tracheostomy 'yes' and oxygen therapy 'yes'. A review of the physician orders dated 2/6/21, documents in part, Suction as needed to maintain patent airway and every shift. Trach [tracheostomy] care daily and as needed. Remove disposable and dispose of inner cannula. Replace with new inner cannula as needed to reduce the risk of infection. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #24's comprehensive care plan dated 2/6/21 and revised on 2/19/21, failed to evidence tracheostomy care for Resident #24 was addressed. The comprehensive care plan, documents in part, FOCUS-The resident has altered respiratory status/difficulty breathing related to tracheostomy status. INTERVENTIONS-Administer medications as ordered elevate head of bed 30 degrees, monitor changes in orientation, anxiety and air hunger. Monitor for signs and symptoms of respiratory distress and report to physician. Monitor and report abnormal breathing patterns to physician. Position resident with proper body alignment for optimal breathing pattern. A review of the admission evaluation dated 2/6/21, documented in part, Clinical evaluation-neurological: identify areas of weakness- right upper extremity, left upper extremity, right lower extremity, left lower extremity (all four areas checked). Clinical evaluation-musculoskeletal: upper extremity range of motion-impairment on both sides, lower extremity range of motion-impairment on both sides. A review of the medical practitioner full assessment dated [DATE], documented in part, Musculoskeletal decreased ROM and weakness-atrophy or spasticity were checked. Abnormal findings documented-contracture of right hand. Range of Motion was not identified as a focus on the comprehensive care plan provided for Resident #24. An interview was conducted on 4/21/21 at 8:53 AM with LPN (licensed practical nurse) #1, regarding the purpose of the comprehensive care plan. LPN #1 stated, The comprehensive care plan is the plan of care for the resident based on physician orders, assessment and unresolved goals from baseline care plan. It gives us the interventions we need for the resident. An interview was conducted on 4/21/21 at 11:53 AM with ASM (administrative staff member) #3, the quality consultant. When asked who completes the comprehensive care plan, ASM #3 stated, The care plan is completed by the IDT (inter-disciplinary team) or the nurse. When asked who provides revisions to the care plan, ASM #3 stated, The IDT or anyone who finds a change should revise the care plan. An interview was conducted on 4/22/21 at 8:17 AM with RN (registered nurse) #3, the interim unit manager, regarding the purpose of the comprehensive care plan. RN #3 stated, The care plan is individualized to the unique needs of the resident. A multi-disciplinary team develops the care plan to make it specific to the resident. The care plan should include trach (tracheostomy), care, suctioning, frequency of dressing change, inner cannula change and cleaning. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concern on 4/21/21 at 5:40 PM. The facility's Interdisciplinary Care Planning policy dated 3/2018, documents in part, The comprehensive care plan describe the following: the services that are to be furnished to maintain the patient's highest practicable physical, mental and psychosocial wellbeing. No further information was provided prior to exit. References: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 37. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 137. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 574. 42106 5. The facility staff failed to implement the comprehensive care plan for care and services of a tracheostomy for Resident #44. Resident #44 was admitted to the facility with diagnoses that included but were not limited to nontraumatic intracerebral hemorrhage (1) and tracheostomy (2). Resident #44's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 3/12/21 coded Resident #44 as being non-verbal and severely impaired of making daily decisions. Section G coded Resident #44 as being totally dependent on two or more staff members for bed mobility, dressing and toileting and totally dependent on one staff member for eating and personal hygiene. Section O coded Resident #44 as receiving oxygen, suctioning and tracheostomy care while a resident at the facility. The comprehensive care plan for Resident #44 dated 12/15/2020 documented in part, Has/At risk for respiratory impairment related to tracheostomy. Date Initiated: 12/15/2020. Revision on: 03/16/2021. Under Interventions it documented in part, .Administer oxygen as per physician order: 5 L (liter) via cool mist humidifier. Date Initiated: 12/15/2020 .Maintain replacement trach (tracheostomy) tube and Ambu bag (3) at bedside. Date Initiated: 12/15/2020 . The physician orders for Resident #44 documented in part, .Cool air mist via trach collar continuous with O2 (oxygen) titrated in at 5 liters every shift for respiratory failure. (4) Order Date: 12/03/2020 . PRN (as needed) as needed for trach care. Order Date: 05/28/2020 . On 4/20/21 at approximately 10:45 a.m., an observation was conducted of Resident #44 in their room. Resident #44 was observed in bed and was observed to have a tracheostomy. Resident #44 was observed wearing a tracheostomy collar mask (oxygen delivery device) delivering oxygen at 5 lpm (liters per minute). Observation of the humidifier bottle attached to the oxygen tubing, revealed it was empty. Observation of the tracheostomy mask, tubing and humidifier bottle, failed to reveal a date on any of the items. A suction machine was observed on the nightstand beside Resident #44's bed with approximately 200 ml (milliliters) of yellowish colored liquid inside the canister. Suction tubing was observed attached to the canister and coiled around the suction equipment, no suction catheter was observed opened. Suction catheter kits, tracheostomy cleaning kits and replacement tracheostomy inner cannulas were observed stored in Resident #44's room. No ambu bag was observed in Resident #44's room. Additional observations on 4/20/21 at 1:34 p.m. and 3:45 p.m. revealed the same findings as above. On 4/21/21 at approximately 9:30 a.m., observation revealed the humidifier bottle was half full. The tracheostomy mask, tubing and bottle remained undated and no ambu bag was observed in the room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29125 Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to review and revise a comprehensive care plan for 4 of 25 residents in the survey sample, (Residents #60, #25, #19, and #44). The facility staff failed to review and revise the comprehensive care plans for Resident #60 and Resident #25 to address urinary tract infections and the care and treatment prescribed, and failed to review and revise Resident #44's comprehensive care plan to address a worsening of a pressure ulcer. 2. The facility staff failed to review/ revise Resident #25's comprehensive care plan when he developed a urinary tract infection on 3/24/21. 3. The facility staff failed to review and revise Resident #19's comprehensive care plan when the resident developed a pressure injury on 2/10/21. 4. The facility staff failed to review and/or revise Resident #44's comprehensive care plan to address a worsened pressure ulcer (1). The findings include: 1. Resident #60 was admitted to the facility on [DATE] with the diagnoses of but not limited to Moyamoya disease, quadriplegia, seizures, high blood pressure, chronic kidney disease, depression, cerebrovascular disease, and human immunodeficiency virus. The most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 3/29/21, coded the resident as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating, which the resident was coded as requiring extensive assistance. A review of the clinical record revealed a physician's order dated 4/16/21 for Macrobid Capsule (1) 100 MG (milligrams) (Nitrofurantoin Monohyd Macro) Give 1 capsule by mouth every 12 hours for Uti (urinary tract infection) for 7 Days. A nurse practitioner progress note dated 4/16/21 at 6:10 PM documented, .being seen today with complaints of new onset moderate pain with urination that has been present for 5 days. Associated symptoms include frequency. Exacerbating factors include urinary incontinent. Current treatment includes increased fluid intake and Vit C (Vitamin C) (2). UA C&S (Urinalysis with culture and sensitivity) (3) obtained on 4/12/21 reporting positive results. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #60's comprehensive care plan dated 7/8/20, documented, Urinary Incontinence which included an intervention dated 7/8/20 for Report S&S (signs and symptoms) of UTI such as flank pain, c/o (complaints of) burning/pain, fever, hematuria, change in mental status, etc. Further review of this care plan failed to reveal any evidence of being updated to include the above treatment for an active urinary tract infection. Further review of the entire comprehensive care plan also failed to reveal any evidence of being updated for the above treatment of an active urinary tract infection. On 4/21/21 at 3:07 PM in an interview with LPN #2 (Licensed Practical Nurse), she stated that the care plan should be updated to include the antibiotic treatment for a new/current infection. LPN #2 stated that change in conditions should be added to the care plan. A review of the facility policy, Interdisciplinary Care Planning documented, As the care plan is implemented, members of the interdisciplinary team need to evaluate whether the interventions are effective or whether the care plan needs to be revised. Evaluating the effectiveness of care plan interventions will help the disciplinary team modify the care plan as needed to help the patient reach their highest practicable level of well-being. On 4/21/21 at 6:00 PM at the end of day meeting, ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. References: (1) Macrobid - is used to treat urinary tract infections. Information obtained from https://medlineplus.gov/druginfo/meds/a682291.html (2) Vitamin C - Vitamin C is an antioxidant. It is important for your skin, bones, and connective tissue. It promotes healing and helps the body absorb iron. Information obtained from https://medlineplus.gov/vitaminc.html (3) UA C&S - A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes. A urine culture is a lab test to check for bacteria or other germs in a urine sample. Sensitivity analysis determines the effectiveness of antibiotics against microorganisms (germs) such as bacteria that have been isolated from cultures. Information obtained from https://medlineplus.gov/urinalysis.html and https://medlineplus.gov/ency/article/003751.htm and https://medlineplus.gov/ency/article/003741.htm 32642 2. The facility staff failed to review/ revise Resident #25's comprehensive care plan when he developed a urinary tract infection on 3/24/21. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #25 was admitted to the facility on [DATE] with diagnoses including epilepsy, COPD (chronic obstructive pulmonary disease) (1), and diabetes (2). The most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/16/21, coded Resident #25 was coded as moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). He was coded as being totally dependent on the assistance of staff members for all activities of daily living. Resident #25 was coded as having a Foley catheter (3) in place. Resident #25 declined to be interviewed during the survey. On the following dates and times: 4/20/21 at 11:40 a.m., 4/20/21 at 12:47 p.m., 4/20/21 at 1:48 p.m., and 4/21/20 at 9:11 a.m. observation revealed Resident #25 lying on his back in bed. During each observation, a Foley catheter collection bag, contained in a privacy cover, was hanging on the bed frame. The catheter was observed draining light yellow urine. A review of Resident #25's admission nursing assessment dated [DATE] revealed documentation confirming Resident #25 had a Foley catheter in place on admission. A review of Resident #25's physicians' orders revealed the following order, dated 3/6/21: Foley output every shift for monitoring purpose. There was no order for urinary output monitoring prior to 3/6/21. A review of Resident #25's physicians' orders revealed the following order, dated 3/4/21: Foley catheter care q (each) shift. Further review of Resident #25's clinical record revealed the following physician order, dated 3/24/21: Levofloxacin Tablet (5) 250 mg give one tablet via PEG (percutaneous endoscopic gastrostomy) tube (4) one time a day for UTI (urinary tract infection). Review of Resident #25's comprehensive care plan dated 2/22/21 revealed no information related to the resident's Foley catheter, a urinary tract infection or the care and treatment prescribed. On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed, regarding the purpose of a care plan. LPN #2 stated it is to make sure that all a resident's needs are met, and that the outcomes are accomplished. When asked if a resident's urinary catheter should be included in the care plan, she stated it should. When asked if a resident's care plan should be updated if he develops an infection and is placed on an antibiotic, LPN #2 stated the care plan should be updated. On 4/21/21 at 3:08 p.m., CNA (certified nursing assistant) #3 was interviewed, regarding the purpose of a resident's care plan, she stated it is to make sure all the needs of a resident are met. CNA #3 stated the staff should always be asking what they could do to improve. She stated the staff should always be asking how the resident wants things done. On 4/21/21 at 6:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22//21 at 1:41 p.m., LPN #5 was interviewed. She stated the purpose of a care plan is to make sure the things a resident needs to be cared for are all in place. LPN #5 stated a resident's urinary tract infection and antibiotic order should be added to the care plan. She stated the nurse who receives the lab [laboratory] result or the antibiotic order is responsible for updating the care plan. No further information was provided prior to exit. REFERENCES (1) COPD is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and [NAME], page 124. (2) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (3) A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder. This information is taken from the website https://medlineplus.gov/ency/article/003981.htm. (4) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm (5) Levofloxacin (Levaquin) is used to treat certain infections such as pneumonia, and kidney, prostate (a male reproductive gland), and skin infections. Levofloxacin is also used to prevent anthrax (a serious infection that may be spread on purpose as part of a bioterror attack) in people who may have been exposed to anthrax germs in the air, and treat and prevent plague (a serious infection that may be spread on purpose as part of a bioterror attack. Levofloxacin may also be used to treat bronchitis, sinus infections, or urinary tract infections but should not be used for bronchitis and certain types of urinary tract infections if there are other treatment options available. Levofloxacin is in a class of antibiotics called fluoroquinolones. It works by killing bacteria that cause infections. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697040.html. 31753 3. The facility staff failed to review and revise Resident #19's comprehensive care plan when the resident developed a pressure injury on 2/10/21. Resident #19 was admitted to the facility on [DATE]. Resident #19's diagnoses included but were not limited to end stage renal disease, diabetes and muscle weakness. Resident #19's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/7/21 coded the resident as being cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's clinical record revealed the resident developed a pressure injury (1) measuring 0. 3-0.6 square centimeters on the left great toe on 2/10/21. Review of Resident #19's comprehensive care plan dated 2/1/21 failed to reveal the care plan had been reviewed and revised when the resident developed the pressure injury on 2/10/21. On 4/22/21 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the purpose of the care plan is to make sure things that patients need are in place to care for them properly. LPN #5 stated care plans should absolutely be reviewed and revised when a resident develops a pressure injury. On 4/22/21 at approximately 5:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. No further information was presented prior to exit. Reference: (1) A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. This information is taken from the National Pressure Ulcer Advisory Panel website https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf 42106 4. The facility staff failed to review and/or revise Resident #44's comprehensive care plan to address a worsened pressure ulcer (1). Resident #44 was admitted to the facility with diagnoses that included but were not limited to nontraumatic intracerebral hemorrhage (2) and tracheostomy (3). Resident #44's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 3/12/21 coded Resident #44 as non-verbal and severely impaired of making daily decisions. Section G coded Resident #44 as totally dependent on two or more staff members for bed mobility, dressing and toileting and totally dependent on one staff member for eating and personal hygiene. Section M coded Resident #44 having one unstageable pressure ulcer. The comprehensive care plan for Resident #44 dated 12/03/2020 documented in part, At risk for alteration in skin integrity related to impaired mobility. Date Initiated: 12/03/2020. Revision on 12/15/2020. The care plan further documented Open area to sacrum. Date Initiated: 01/29/2021. Created on: 01/29/2021. The care plan failed to document any revisions or updates since 1/29/2021. The current physician orders for Resident #44 documented in part, - Body Audit- daily one time a day for skin observation. Order Date: 03/08/2021. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Sacral (4) wound- cleanse with normal saline, pack with anasep (wound cleanser) and 4x4's (gauze), skin prep (liquid film-forming dressing) peri wound (around the wound), cover with dry protective dressing, cover with transparent dressings. Change daily and prn (as needed) until resolved or no longer indicated. Order date: 03/29/2021. The progress notes for Resident #44 documented in part the following: - 1/13/2021 16:31 (4:31 p.m.) Note Text: Treatment order changed to sacrum area, cleanse with NS (normal saline) apply barrier cream cover with foam dressing q (every) day and prn. (as needed) Noted area to be 5cmx3cmx0.1cm (5 centimeters length by 3 centimeters width by 0.1 centimeters depth). Resident turned and re-positioned frequently. - 1/20/2021 16:59 (4:59 p.m.) Late Entry: Note Text: Wound care to sacrum measuring 6.0cm x 3.0 cm x 0. 1cm (6 centimeters length by 3 centimeters width by 0.1 centimeters depth). Resident turned and re-positioned frequently. Cleansed with NS apply barrier cream cover with foam dressing daily and prn. - 2/11/2021 16:37 (4:37 p.m.) Note Text: L (left) buttock 3.8 cm x 6.0 cm (3.8 centimeters length by 6.0 centimeters width) area with 90% eschar (5) and 10% slough (6) with purulent (containing pus) drainage with foul odor noted. R (right) buttock area 1.5cm x 3cm (1.5 centimeter length by 3 cm width) with slough and purulent drainage noted. - 2/24/2021 10:00 (10:00 a.m.) Note Text: Wound rounds completed. Wound bed is 40% granulation tissue (7), 30% slough, and 30% eschar, wound borders are irregular and unattached. A large amount of foul smelling, purulent drainage is noted on the dressing removed. Peri wound (around the wound) is normal skin tissue. Wound care provided according to Physician's orders. Dressing is changed daily and prn until resolved or no longer indicates use of Santyl (wound ointment to remove dead tissue) to wound bed. - 3/3/2021 04:02 (4:02 a.m.) Note Text: Wound round completed on this Patient. Sacral wound measures (6. 8 x 11.8 total affected area) (6.8 length by 11.8 width) 4.0 x 6.0 (center of wound) (4.0 length by 6.0 width) x depth immeasurable due to slough in wound bed, undermining (tunneling) of 3.0 @ 12 (at 12:00 position) is present, slough covering 90% of wound bed is thick, gray [sic],and adherent, 10 % granulation tissue present; borders are irregular and unattached, copious amount of purulent foul odor is present, peri wound is discolored. Continue with current treatment, change daily and prn (as needed) until resolved . - 3/10/2021 06:47 (6:47 a.m.) Note Text: Wound round completed. Sacrum measures 5.8 x 11.8 x immeasurable (5.8 length by 11.8 width by depth), wound bed is 80% gray [sic] slough, 10% granulation tissue, and 10% skin, borders are irregular and unattached, there is a copious amount of foul smelling purulent drainage, peri wound is normal . - 4/3/2021 19:43 (7:43 p.m.) Note Text: Wound care completed. Sacrum measures 5.8 x 5.7 x 4 x 3.5 (5.8 length by 5.7 width by 4 depth by 3.5 undermining). Unstageable. Wound bed is 80% gray [sic] slough, 10% granulation tissue, and 10% skin, borders are irregular and unattached, there is a copious amount of serosanguineous (8) drainage, peri wound is normal. Treatment as ordered by Dr (doctor). L (left) plantar area is resolved, continue to skin prep for prevention. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/14/2021 13:54 (1:54 p.m.) Late Entry: Note Text: Wound round completed. Wound is progressing. Sacral wound total area affected is 7.7 x 8.9 (7.7 length by 8.9 width); 80% granulation, 20% skin; area that is packed (within first measurement) is 6.0 x 6.5 x 2.5 x 3.8 (6.0 length by 6.5 width by 2.5 depth by 3.8 undermining) @12 (at 12:00 position). Wound bed is fully granulated, borders are clean and irregular, there is a copious (large) amount of bloody drainage on dressing removed and new bleeding noted. Peri wound is normal also with some small areas of pink scar tissue. Treatment to be changed to Anasep liquid. - 4/21/2021 12:58 (12:58 p.m.) Note Text: Sacral wound assessed. Wound bed 80% moist granulation tissue and 20% grey/ black slough with moderate amount serosanguineous drainage noted. Peri-wound macerated. Based on physical appearance and drainage, this will be classified as a stage IV (9) sacral wound. rp/ md (responsible party/nurse practitioner and or physician) aware. - 4/22/2021 10:16 (10:16 a.m.) Note Text: Sacral wound measures 7.8 cm x 8.2 cm x 0.4 cm (7.8 centimeters length by 8.2 centimeters width by 0.4 centimeters depth). NP (nurse practitioner) notified. Order updated this am (morning) to bid (twice a day) due to drainage amount. rp (responsible party) aware. On 4/21/21 at approximately 3:00 p.m., an observation was made of RN (registered nurse) #1 performing wound care to Resident #44's sacral wound. RN #1 stated that they had not seen Resident #44's wound prior to that day and could not speak to how the wound previously looked. RN #1 described Resident #44's wound as a Stage IV pressure ulcer and stated that they had recommended changing the treatment that was in place to the wound. Resident #44's wound was observed to be open, moist with a moderate amount of serosanguineous drainage. On 4/22/21 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that care plans were in place to make sure the patients' needs were being met and to provide the best care. LPN #8 stated that care plans were revised and updated when a treatment was changed or there was a change in condition. LPN #8 stated that a worsened pressure ulcer should require a review of the care plan to ensure that all appropriate interventions were in place to promote wound healing. The facility policy Interdisciplinary care planning dated updated 03/2018 documented in part, .The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive . The policy further documented, .Once the care plan is developed, the staff must implement the interventions identified in the care plan. These may include, but is not limited to: administering medications and treatments .Evaluating means monitoring patients' progress toward their goals. Evaluation may result in: identifying factors affecting progress toward achieving goals, defining or redefining a patient's prognosis, adjusting treatment plans or interventions, or identifying when care objectives have been achieved and discharge, transfer, or a change in level of care is appropriate . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Skin Practice Guide dated 2013 documented in part, .If a change in patient condition occurs, such as a deterioration in or development of new risk factors or skin alterations, the licensed nurse notifies the physician, wound team, family or responsible party and documents findings in the clinical record. The patient's plan of care is then updated to reflect the patient's current status and care needs . The policy further documented, .The approached for skin management are clear, specific and individualized for the patient's needs. Managing skin risk can be complex as there may be a combination of risk factors and causes. Regardless of the interventions that are put in place, a key factor to success is the timely review of the interventions as the patient's condition and needs change. Updates to the care plan are reflected on the Patient Information Worksheet, Kardex and Task List . On 4/22/21 at approximately 9:45 a.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. Reference: 1. Pressure ulcer are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000147.htm. 2. Intracerebral hemorrhage is bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm. 3. Tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. 4. Sacral: The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm 5. Eschar is dead tissue that falls off (sheds) from healthy skin. It is caused by a burn or cauterization (destroying tissue with heat or cold, or another method). This information was obtained from the website: https://medlineplus.gov/ency/article/002355.htm 6. Slough is soft, moist avascular tissue that adheres to the wound bed in strings or thick clumps; may be white, yellow, tan or green. This information was obtained from the website: https://www.hopkinsmedicine.org/gec/series/wound_care.html#wound_assessment (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Granulation: The wound starts to fill in with new tissue, called granulation tissue. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000741.htm 8. Serosanguineous means contains or relates to both blood and the liquid part of blood (serum). It usually refers to fluids collected from or leaving the body. For example, fluid leaving a wound that is serosanguineous is yellowish with small amounts of blood. This information was obtained from the website: https://medlineplus.gov/ency/article/002306.htm 9. Stage IV pressure ulcer is a pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website:https://medlineplus.gov/ency/patientinstructions/000740.htm.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards for medication administration for one of 25 residents in the survey sample, (Resident #47). The facility staff failed to provide the care and services in accordance with professional standards of practice for documenting the administration of medications on 7/2/2020 for Resident #47. On the evening of 7/2/2020, Resident #47 was inadvertently assigned to both LPN [licensed practical nurse] #4 and RN [registered nurse] #2. LPN #4 administered the residents prescribed evening medications but failed to document the medications as administered on the eMAR [electronic medication administration record], as a result of this failure, RN #2 administered the same medications a second time to the Resident #47 a second time, resulting in a significant medication error and overdose. Resident #47 was subsequently transferred to a local hospital for evaluation/treatment. IV (intravenous) fluids, including dextrose were administered to Resident #47, in the emergency room . The resident then required admission to hospital for monitoring. The findings include: Resident #47 was admitted to the facility on [DATE] and transferred to the hospital on 7/2/20. Resident #47's diagnoses included but were not limited to: bipolar disorder (1), seizures (2), diabetes mellitus (3) and atherosclerosis cardiac disease (4). Resident #47's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 3/15/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident as requiring limited assistance with mobility, transfers, dressing; supervision with personal hygiene and bathing and as independent in eating and locomotion. An annual assessment completed on 5/11/20 prior to the incident on 7/2/20 coded the resident as scoring a 9 out of 15 on the BIMS indicating Resident #47 was moderately impaired for cognition. Section N0350 Insulin: coded the resident as receiving insulin injections 7 out of 7 days of the look back period. The physician orders for Resident #47 in July 2020, documented in part the following: Medications scheduled administration time 5:00 PM: - Losartan (anti-hypertensive) (5) 100 milligram table by mouth in the afternoon for hypertension - Multivitamin (dietary supplement) 1 tablet by mouth in the afternoon for supplement, - Divalproax [Depakote] (anti-epileptic) (6) 625 milligram delayed response tablet twice a day for seizure prevention, - Metformin (anti-diabetic) (7) extended release tablet 500 milligram by mouth twice a day for diabetes mellitus, (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	- Olopatadine (treats allergic conjunctivitis) (8) solution 0.1% instill 1 drop in both eyes twice a day for allergies, - Humalog Mix 75/25- inject 50 units subcutaneously twice a day before breakfast and dinner, notify MD if blood sugar less than 60 or greater than 400. Hold Humalog 75/25 if blood sugar is less than 100. - Humalog (insulin) (9) 100 units/milliliter inject per sliding scale: if BS (blood sugar) 150-200 =4 units, BS 201-250=6 units, BS 251-300=8 units, BS 301-350=10 units, BS 351-400=12 units. If < 60 or > 350 or greater call physician, subcutaneously before meals for diabetes. Medications scheduled administration time 9:00 PM: - Atorvastin (anti-hyperlipidemic) (10) 10 milligram tablet by mouth at bedtime to lower cholesterol - Cetirizine (antihistamine) (11) 5 milligram tablet at bedtime for allergies - Gabapentin (anti-epileptic) (12) 600 milligram tablet at bedtime for nerve pain - Melatonin (treatment for insomnia) (13) milligram tablet by mouth at bedtime for sleep - Ziprasidone (antipsychotic) (14) 40 milligram capsule at bedtime for bipolar - Bisoprolol (antihypertensive) (15) 10 milligram twice a day for hypertension A FRI (facility reported incident) with an incident dated 7/2/20, and a reported date of 7/3/20, documented in part, Resident was given evening medication twice by two nurses. Resident's nurse practitioner requested the resident be sent to the hospital to be monitored due to the medication and her low blood pressure/pulse. Resident was admitted at the hospital for observation. Patient has no negative outcomes at this time. Employee action initiated or taken: Suspension/removed from schedule while investigation ongoing. Improvement plan and education initiated. If applicable date notification provided to: Responsible party: 7/3/2020, Physician: 7/3/2020, APS [adult protective services]: 7-3-2020, DHP [Department of Health Professions]: 7/3/2020 Review of the FRI investigation and follow up, documented in part, the following: Facility investigation: Completed on: the date 7/8/2020 was handwritten on the form. An included attachment documented in part the following: 7-8-2020 FRI day 5 (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 7/2/2020 it was reported that a resident was given medication twice by two different nurses. During the investigation it was found that the resident was written on two different assignment sheets, [name of LPN #4] gave the medication first, without documenting the medication in the system. [Name of RN #2] gave the medication second. The MD [medical doctor] was notified and gave an order to send the resident to the ER [emergency room]. Resident [#47] was sent to the hospital and remained there two nights under observation status. Resident [#47] returned to the facility on [DATE] with no adverse reactions from the medication error and has remained stable. The DON [director of nursing] removed both nurses from the schedule while the investigation was ongoing, reconfigured the assignment sheets as well as educated the nursing staff on proper medication documentation. The investigation is complete. Another attachment titled, Trigger Call Guideline/Agenda documented in part the following: Event Type: Medication Error Date and Time of Event: 7/2/20@ [at]9pm Patient Name: [Name of Resident #47] Cognitive Status/BIMS (date last completed): 9 as of 5/11/20 Timeline of Events: [Name of LPN #4] (Agency Nurse) administered the following medications to [name of Resident #47] at around 5:20pm: 4 units of Humalog insulin Humalog Mix 75/25- 50 units Metformin ER [extended release] 500 mg (milligram) MVI (multivitamin) Depakote 625 mg Losarten Potassium 100mg Bisoprolol Fumrate 10mg OlapTADINE HCL (hydrochloride) eye gtts (drops) [Name of LPN #5] administered the following medications around 8pm: Atrovastin Calcium 10mg Gabapentin 600mg Melatonin 1mg (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ziprasidone HCL 40mg Around 9pm [Name of RN #2] asked [Name of LPN #4] to compare assignments to make sure that no one was missed. At that time they noticed that they both had [Name of Resident #47] on their assignment sheets and they both had given her [Resident #47] her scheduled medications. They both [RN #2 and LPN#4] both went immediately to assess the resident. The resident [Resident #47] was sleeping. She [Resident #47] was easily aroused and responsive to questions. Vital signs were taken at that time. BP 95/47, 57, 16, 96% on RA [blood pressure, pulse, respirations and oxygen saturation on room air]. [Name of nurse practitioner] was notified immediately and orders were received to sent [Sic] resident to ER [emergency room]. When EMT's [emergency medical technicians] arrived resident was able to answer questions and she walked to the stretcher. EMS [emergency medical services] took her [Resident #47] blood sugar which was 146. Resident was transported to [Name of hospital]. [Name of RN #2] called report to the ER Nurse to inform her of what medications the resident [Resident #47] received in duplicate. [Name of Resident #47's] Emergency Contact was notified of details of the incident this morning by [name of staff LPN]. DON called [Name of Resident #47's emergency contact] around 10am to explain the incident to her. During the investigation it was discovered that [Name of Resident #47] only received her Humalog 75/25 50 units once by [Name of LPN #4]. [* Note the sliding scale insulin was administered twice by both nurses for a total of 8 units of Humalog 100units/ ml]. Education has been initiated on Medication Administration to include signing off medications as you administer them to include giving medications timely as scheduled. The assignments sheets for the units were updated The final investigation included: Statements by RN (registered nurse) #2 and LPN (licensed practical nurse) #4, both involved in the medication error event. The MAR (medication administration record) for July 2020 for Resident #47 with initials sign on code of KO9 corresponding to RN #2. The Assignment sheets for RN #2 and LPN #4. A review of the clinical record failed to evidence any progress notes documenting the events of 7/2/20, regarding a medication error and/ or the residents transfer to the hospital. A review of vital signs on 7/2/20 at 6:23 AM, documented in part, Blood pressure 138/65, pulse 70. Resident #47's blood sugar at 4:30 PM was documented as 179. A review of a Discharge return anticipated MDS assessment with an assessment reference date of 7/2/20, documented in part, Unplanned transfer to acute hospital. A review of the hospital records for Resident #47, evidenced admission to an acute care hospital on 7/2/20-7/4/20. The emergency room record documented in part: EKG: Sinus bradycardia (low heart rate) rate of 51. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Emergency Department (ED) physician notes dated 7/2/20 11:28 PM, documented in part, She [Resident # 47] presents after getting a double dose of her medications which include extended release Metformin and Losartan. Her blood sugar dropped from 108 to 81. Her blood pressures have been on the soft side with maps (mean arterial pressures) around 65. She is getting a fluid bolus and I have ordered maintenance D5 (dextrose 5%) normal saline. Virginia Poison Control was contacted and suggests admission as Metformin was extended release and requires at least 12 hours of observation. She reports feeling sleepy, weak and somewhat confused. The ED (emergency room) RN [registered nurse) note dated 7/2/20 at 11:00 PM documented in part, RN spoke with 'RN#2' taking care of patient from the facility. States that patient received a double dose of her evening medication. 'RN#2' states patient was given medications around 6:00 PM and again at 9:00 PM. A review of the hospital discharge summary dated 7/4/20, documented in part, Admitting diagnosis and hospital course: Accidental overdose and hypoglycemia secondary to iatrogenic [Referring to a physical or mental condition caused by a physician or healthcare provider*] insulin. Discharge Diagnosis/Plan: Accidental overdose-patient now back to baseline. EKG (electrocardiogram) x two with normal QT intervals. Diabetes Type 2-resume sliding scale insulin. Initially insulin held on admission. Hypertension-blood pressure soft due to overdose. Received IV (intravenous) fluids in ED. BP stable at this time. LPN #4, an agency nurse, was not available for an interview and was not employed at the facility. An interview was conducted on 4/22/21 at 4:56 PM with RN #2, the nurse supervisor. RN #2 was the second nurse who administered medications to Resident #47 on 7/2/20. When asked if she remembered the medication error on 7/2/20, RN #2 stated, Oh yes, that was the error with the agency nurse who gave medicines and didn't chart, either time. I came to give the medications to the resident [Resident #47] on my assignment sheet and since they were not signed off, I gave the 6:00 PM and 9:00 PM medications. I did not know we were both assigned to the resident until about 9:00 PM. If I had seen the medications signed off, I would have asked the other nurse about the assignment and the medications. I checked on the resident and saw that she did not look well, so I called the nurse practitioner and we transferred her to the hospital. When asked if she remembered any changes or education that were made because of the medication error, RN #2 stated, Yes, they changed the assignment sheet and the number of medication carts. We also reviewed the medication administration policy. On 4/20/21 at 10:40 AM, during the entrance conference, when asked what standards of practice were followed, ASM (administrative staff member) #2, the director of nursing and ASM #3, the quality consultant stated, We use [NAME] and [NAME] & [NAME]. Administrative staff members (ASM) # 1, the administrator was made aware of the above concerns on 4/22/21 at 5:56 PM. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concerns on 4/23/21 at 10:08 AM. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	According to Basic Nursing, Essentials for Practice, 6th edition ([NAME] and [NAME], 2007, pages 349-360) A medication order is required for you to administer any medication to a patient. Once you receive and process a medication, place the physician's or health care provider's complete order on the appropriate medication form, the MAR. The MAR includes the patient's name, room, and bed number, as well as the names, dosages, frequencies, and routes of administration for each medication. When transcribing orders, ensure the names of medications, dosages, routes, and times are legible. The nurse checks all orders for accuracy and thoroughness. When orders are transcribed, the same information needs to be checked again by the nurse. It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the six rights of medication administration. 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation .Use the MAR to prepare and administer medications. When preparing medications in bottles or containers, compare the label of the medication container with the medication administration order three times: (1) before removing the container from the drawer or shelf, (2) as you remove the amount of medication ordered from the container, and (3) before returning the container to storage .After you administer medications, indicate which medications you gave on your patient's MAR per agency policy to show that you gave the medications as ordered. Inaccurate documentation of medications, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about your patient's care. There are many nursing actions you take to ensure the right documentation. Make sure that the information on your patient's MAR corresponds exactly with the prescriber's order and with the label on the medication's container. Record the administration of each medication as soon as you give the medication. Never document that you have given a medication until you have actually given it. A review of the facility assessment evidenced the facility Skills Competencies dated 10/2017, which documented in part, Medication management skills evaluation documents validation of medication management techniques and knowledge completed during job specific orientation and annually. The Medication Management Skills Evaluation CLS-228 (5/14), documented in part, Documents at time of administration on MAR/eMAR. Initiates incident report for medication administration errors. A review of the facility's Medication and Treatment Administration Guidelines dated 3/2018, documented in part, Medications and treatments administered are documented immediately following administration or per state specific standards. The facility enacted a plan of correction, which contained the following 5 points: 1. Nurse practitioner was immediately notified of medication administration error on 7/2/20 once discovered. LPN #4 and RN #2 administered medications at 5:00 PM and 9:00 PM. LPN #4 and RN #2 were both assigned to Resident #47. LPN #4 failed to document administration of medications at 5:00 PM and again at 9:00 PM. RN #2 administered 5:00 PM and 9:00 PM medications to Resident #47 as they had not been documented as given and she was unaware that LPN #4 was also assigned to Resident #47. 2. All Residents with medication administration of their prescribed medications including anti-hypertensive, diabetic, anti-hyperlipidemia, anti-epileptic, anti-psychotic and insulin have the potential to be affected by this deficient practice. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	3. All Nurses educated in person or via phone on 7/3/20 regarding the facility's Medication Administration policy [to include proper documentation after administration] dated 3/2018. LPN #4, an agency nurse, the nurse responsible for administration of the first dose of the 5:00 PM and the 9:00 PM medications was second check was terminated from the facility. 4. For the next month, an audit of medication administered and documented were reviewed by the director of nursing. The medication types reviewed included: anti-hypertensive, diabetic/insulin, anti-hyperlipidemia, anti-epileptic and anti-psychotic. All results and findings were presented and reviewed at the Quality meeting in August 2020. 5. Completion date 7/8/20. The credible evidence including the Plan of Correction, education, in-service sign in sheets, audits and Quality Council minutes were reviewed and found to be in order. Random interviews were conducted with staff on varying shifts regarding medication administration and documentation and failed to reveal any concerns. A medication pour/pass observation was completed during this survey and no concerns were identified including no concerns for the documentation of medications administered. No further significant medication errors were identified. Review of current residents failed to identify any concerns. Past Noncompliance References: (1) Bipolar disorder is a mental disorder characterized by periods of mania and depression. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 71. (2) Seizures: a sudden, involuntary and violent contraction of a group of muscles, sometimes with loss of consciousness. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 137. (3) Diabetes mellitus: inability of insulin to function normally in the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 160. (4) Atherosclerosis cardiac disease: disorder of the cardiac arteries caused by a buildup of plaque which results in the vessels becoming non-elastic. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 52. (5) Losartan potassium tablets are indicated for the treatment of hypertension in adults Overdosage: Limited data are available in regard to overdosage in humans. The most likely manifestation of overdosage would be hypotension and tachycardia; bradycardia could occur from parasympathetic (vagal) stimulation. If symptomatic hypotension should occur, supportive treatment should be instituted. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cda520b7-ae84-4bd7-b298-11934f4fcc57 (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	(6) Depakote ER [extended release] is a valproate and is indicated for the treatment of acute manic or mixed episodes associated with bipolar . Overdosage with valproate may result in somnolence, heart block, deep coma, and hypernatremia. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0dc024ce-efc8-4690-7cb5-639c728fccac (7) Metformin hydrochloride extended-release tablets are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. BOXED WARNING: Postmarketing cases of metformin-associated lactic acidosis have resulted in death, hypothermia, hypotension, and resistant bradyarrhythmias This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f0371d2a-276b-4acb-80f8-e24fb8ceae19 (8) [NAME] Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 443. (9) HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children. 5 Warnings and Precautions: 5.3 Hypoglycemia: Hypoglycemia is the most common adverse reaction associated with insulins, including HUMALOG. 10. Overdosage: Excess insulin administration may cause hypoglycemia and hypokalemia. Mild episodes of hypoglycemia usually can be treated with oral glucose. More severe episodes may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f (10) [NAME] Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 32. (11) [NAME] Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 67 (12) Gabapentin is indicated for: Management of postherpetic neuralgia in adults Adjunctive Gabapentin is indicated for: Management of postherpetic neuralgia in adults Adjunctive therapy in the treatment of partial onset seizures, with and without secondary generalization, in adults and pediatric patients 3 years and older with epilepsy Overdosage: Symptoms have included double vision, tremor, slurred speech, drowsiness, altered mental status, dizziness, lethargy, and diarrhea. Fatal respiratory depression has been reported with gabapentin overdose, alone and in combination with other CNS depressants. https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=f1bce199-9f88-4a94-9006-8e148dedd45f&version=3 (13) [NAME] Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 429. (14) Ziprasidone capsules are indicated for the treatment of schizophrenia, as monotherapy for the acute treatment of bipolar manic or mixed episodes. Overdoasge: (in part) cardiovascular monitoring should commence immediately and should include continuous electrocardiographic monitoring to detect possible arrhythmias. Hypotension . should be treated with appropriate measures such as intravenous fluids. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=6485d78e-ca4e-4217-ad80-c784a15fa6a4&version=7 (15) BISOPROLOL FUMARATE is indicated in the management of hypertension. Overdosage: The most common signs expected with overdosage of a beta-blocker are bradycardia, hypotension, congestive heart failure, bronchospasm, and hypoglycemia. This information was obtained from the website https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d82243b9-3e56-4a2b-8750-cb95ec106885 (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	* This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/iatrogenic

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for one of 25 residents in the survey sample, Resident #19. On three Sundays in March 2021, the facility staff failed to provide assistance with transfers, dressing or personal hygiene, to Resident #19, who was assessed as requiring extensive assistance of one staff with personal hygiene and dressing. The findings include: Resident #19 was admitted to the facility on [DATE]. Resident #19's diagnoses included but were not limited to end stage renal disease, diabetes and muscle weakness. Resident #19's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/7/21, coded the resident as being cognitively intact. Section G coded Resident #19 as requiring extensive assistance of one staff with personal hygiene and dressing. Section G further documented transfers did not occur during the assessment look back period. Resident #19's comprehensive care plan dated 2/2/21 documented, ADL Self care deficit. Assist with daily hygiene, grooming, dressing, oral care and eating as needed. On 4/20/21 at 1:44 p.m., an interview was conducted with Resident #19. Resident #19 stated the staff did not assist her with getting washed, changing her gown or getting out of bed on some weekends. Resident #19 stated these (ADLs) are only certain to occur during the week when she receives therapy. Review of Resident #19's March 2021 ADL records failed to reveal the resident was assisted with transfers on Sunday 3/7/21, personal hygiene, dressing and transfers on Sunday 3/14/21 and transfers on Sunday 3/28/21, as evidenced by blank spaces on the ADL records for these dates. On 4/21/21 at 5:16 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated residents should be cleaned and dressed, or have their gown changed, daily and residents should be assisted out of bed daily if they want to get up. CNA #4 stated the completion of ADLs should be documented in the computer system ADL records and you can't say the care was provided if it was left blank. On 4/21/21 at 6:08 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility document titled, Focus on F Tag 677 documented, A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . No further information was presented prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to prevent and promote healing of a pressure injury for two of 25 residents in the survey sample, Residents #25 and #44. 1. The facility staff failed to ensure ongoing assessments to include measurements, descriptions and the completion of a PUSH tool for the Resident #25's right lateral fifth toe pressure injury. Resident #25's clinical record revealed a PUSH tool (8) was completed for each of the resident's pressure injuries except for the right lateral foot, fifth toe pressure injury. In addition the facility staff failed to evidence any measurements or description of the right lateral foot, fifth toe pressure injury, from [DATE] through [DATE] and on [DATE]. 2. For Resident #44, the facility staff failed to ensure ongoing assessments to include measurements, descriptions and completion of a PUSH tool (1) assessment for the resident's sacral (2) pressure injury (3). Resident #44's clinical record failed to evidence a PUSH tool assessment of the sacral pressure injury on [DATE], [DATE], [DATE] and the timeframe between [DATE] and [DATE] and between [DATE] and [DATE]. The findings include: 1. Resident #25 was admitted to the facility on [DATE] with diagnoses including epilepsy, COPD (chronic obstructive pulmonary disease) (2), and diabetes (3). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of [DATE], Resident #25 was coded as moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). He was coded as being totally dependent on the assistance of staff members for all activities of daily living. He was coded as having one pressure injury at a stage 1 (4), and one pressure injury at a stage 2 (5). Both pressure injuries were coded as present on admission. Resident #25 declined to be interviewed during the survey. On the following dates and times, [DATE] at 11:40 a.m., [DATE] at 12:47 p.m., [DATE] at 1:48 p.m., and [DATE] at 9:11 a.m., Resident #25 was observed lying on his back in bed. During each observation, Resident #25 was observed wearing pressure-relieving boots on both feet, and resting on a pressure-relieving mattress. A review of Resident #25's admission nursing assessment dated [DATE] revealed documentation of the following skin integrity issues: discolored area to right inner ankle, small open area with discoloration to peri wound (area surrounding the wound) on right inner ankle, left heel, right heel. A review of Resident #21's Braden Scale Assessment for risk of developing pressure injuries dated [DATE] revealed that he was at high risk, having scored 11. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #21's clinical record failed to reveal any measurements of his pressure ulcers on admission. Further review of Resident #25's clinical record failed to reveal a PUSH tool (7) assessment the right lateral foot, fifth toe pressure injury. Further review of Resident #21's clinical record revealed the following documentation regarding his fifth toe pressure injury: - [DATE]: Right lateral 5th toe 1.5 cm x 1.7 cm dark red/purple area with no drainage. - [DATE]: Resident's skin check completed. No bruising, skin tears, or wounds were noted .will continue to monitor for changes in the skin's integrity. - [DATE]: Wound rounds completed on Patient. R (right) 5th toe measures 0.8 x 0.5, skin alteration is dark in color, no drainage noted, peri wound is dry flaky skin. Treatments to areas per Dr (doctor) orders are provided daily and prn (as needed) until resolved. - [DATE]: Wound rounds completed. R 5th toe has irregular borders, neither area has drainage, and both are surrounded by pink scar tissue. All treatments provided as ordered. - [DATE]: R lateral foot near 5th toe is 1.9 x 0.9 dark brown/black intact skin with no drainage. Follow all treatment orders. - [DATE]: Wound round completed. There were no documented assessment, no description or measurements of the R 5th toe pressure ulcer on [DATE]. - There was no documented assessment, description or measurements of the R 5th toe pressure ulcer between [DATE] and [DATE], (a sixteen day period). - [DATE]: Late entry for wound/s. R lateral foot wound near toes is beefy red and 100% granulated, measures 1.7 x 1.8 x 0.2 with irregular borders, moderate serosanguineous drainage noted, peri wound is normal . Continue all treatments per orders - [DATE]: Wound care completed. There were no measurements or description of the R 5th toe pressure injury. - [DATE]: Wound round completed. R lateral foot near 5th toe, wound bed is fully granulated, area measures 1.5 x 1.5 x 0.2, there is a moderate amount of serosanguineous drainage on dressing removed, peri wound is normal, treatment to be changed to puracol plus . Resident has pressure relieving boots on while in bed as tolerated. - [DATE]: Right lateral foot wound is 74% epithelial tissue and 25% moist granulation tissue. MD (medical doctor) notified of wound changes. New order obtained and followed through. Rp (responsible party) (sic) aware (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- [DATE]: .Right lat (lateral) foot distal aspect measures 2 cm x 2.2 cm x <0. (less than) 1 cm. rp/ md aware . Clarification; Wound is 75% epithelial tissue and 25% moist protruding granular tissue with scant seosanguinous (sic) drainage without odor noted. Protruding tissue is soft and boggy to palpation. This will be classified as a healing unstageable pressure ulcer A review of Resident #25's comprehensive care plan, dated [DATE] and updated [DATE], revealed, in part: At risk for alteration in skin integrity related to impaired mobility, DTI (deep tissue injury) (6) to right lateral foot near 5th digit .administer treatment per physician order .open area to left heel .administer treatment per physician orders. On [DATE] at 11:53, ASM (administrative staff member) #3, the quality consultant, ASM #1, the administrator, RN (registered nurse) #1, and ASM #2, the DON (director of nursing) were interviewed regarding the facility's process for assessing, monitoring, and treating pressure injuries. RN #1 stated she was not the wound nurse for this facility, but that she is the wound nurse for a sister facility. She stated she had been asked to come to the facility that morning to help out. ASM #1 stated the wound nurse position at this facility is currently posted, and the facility is actively recruiting candidates to fill the position. RN #1 stated she had not assessed any of the facility wounds until that morning. ASM #1 also stated there was no wound specialist who currently makes rounds and treats residents at the facility. ASM #3 stated the process for a resident on admission is to identify if the resident has any skin integrity issues and to identify the resident's risk for developing a pressure injury. These are done by a Braden scale (to determine risk) and by the admission nursing assessment. If the resident is admitted with pressure injury, the physician is contacted for treatment orders. Additionally, per facility policy, a pressure injury assessment is completed for the resident on admission. She stated if a resident has a pressure injury, he/she is seen weekly during IDT (interdisciplinary team) wound rounds. When asked who composes the IDT team, ASM #3 stated the IDT team includes the DON, unit manager, and wound nurse. ASM #3 stated, They go in every week and look at every wound. She stated someone on the team writes a comprehensive progress note with measurements and a description of the wound. When asked if wound staging is included in the IDT wound rounds each week, ASM #3 stated PUSH tools and staging are used to monitor a wounds progression, healing, or decline. She stated a PUSH tool calculates the size of a wound (surface area) as well as the amount of any material that is coming from the wound (exudate). The PUSH tool also tracks the type of tissue in a wound bed, and uses all of those values to convert the wound to a numerical score. ASM #3 stated this gives a quick look of how the wound is doing. She stated the facility protocol is to develop a PUSH tool for every wound. ASM #3 stated a pressure injury should be assessed weekly. She stated if there is a change in the status of the wound, or something is abnormal, then that should also be documented in a progress note. She stated all pressure injuries and pressure injury treatments should be documented on the resident's care plan. She stated the process is the same for a resident who develops a pressure injury after admission. The staff members present for this interview were informed that a PUSH tool for Resident #25's right lateral foot/fifth toe could not be located. When asked about the lack of evidence of staging for all wounds, ASM #3 stated there is a deficit in staging in the documentation. She stated pressure injuries can still be monitored by weekly wound rounds, PUSH tools, and descriptions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:45 p.m., ASM #5, a physician, was interviewed. ASM #5 was asked about her role in assessing, monitoring, and treating pressure injuries. She stated nursing usually takes care of it. She stated if there is any concern at all, the nurses notify her. She stated she is in the building at least once a week, and is available to see residents. ASM #5 stated the facility now has an in-house wound nurse, and the wound nurse or floor nurses do wound assessments. She stated the nurses will let her know if there is any sign of infection. When asked how she makes decisions regarding a pressure injury treatment, ASM #5 stated she relies on the wound care nurse. When informed that no evidence of wound staging was present in the clinical record, and asked how she determined whether a pressure injury has improved or declined, ASM #5 stated, There should be staging. She stated without staging, it is not possible to tell whether a wound is improving or not. ASM #5 stated it is important to stage to see whether or not a wound is getting better, or if another approach should be tried. When asked if she looks at wounds, ASM #5 stated that most of the time, the wound care has been done, and a dressing is applied to the wounds. ASM #5 added, I understand our concern with the staging. On [DATE] at 6:02 p.m., an end of day conference was conducted with ASM #1, ASM #2, and ASM #3. ASM #1 stated the facility has never had the wound nurse position filled on a permanent basis. She stated an LPN (licensed practical nurse) does many of the wound treatments, but the wound nurse position has been temporarily filled by nursing leadership and by a contract agency. She further stated that there has been a large amount of turnover in nursing leadership positions, especially the DON (director of nursing) position. On [DATE] at 11:31 a.m., ASM #3, ASM #1, and ASM #2 were informed of the lack of a PUSH tool as referenced above for Resident #25. On [DATE] at 12:59 p.m., ASM #6, a physician, was interviewed. He stated he typically does not to look at wounds, although he is available, and is in the building at least once a week. He stated the nursing staff goes to him if they have a question about a wound, but that he is not a part of their routine. When asked specifically about Resident #25's wounds, ASM #6 stated the resident is at a very high risk for developing pressure injuries, and that he would speak to the staff about Resident #25's particular pressure injury. On [DATE] at 1:41 p.m., LPN #5 was interviewed. She stated if she identifies an area of concern with a resident's skin integrity, she reports to the wound care nurse, the supervisor, and the doctor. She stated if she discovers a pressure injury on her shift, she initiates a treatment by communicating with the physician or nurse practitioner. She stated if it is her responsibility to assess a wound, she looks at the size, depth, color, smells, and drainage. LPN #5 stated she also looks carefully at the area surrounding the wound. The facility skin practice guide documented, If a pressure ulcer is identified, a Pressure Ulcer Scale for Healing (PUSH Tool) is initiated by a member of the wound team for each site identified. A comprehensive evaluation is completed and documented in the patient's clinical record and may include, but is not limited to: -location -depth -appearance of surrounding skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-presence and location of tunneling -presence and location of undermining -evidence of infection -pain. No further information was provided prior to exit. REFERENCES (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. (2) COPD is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and [NAME], page 124. (3) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (4) Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. (5) Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 10:45 a.m., an observation was made of Resident #44 in their room. Resident #44 did not respond to verbal prompting. Resident #44 was observed lying in their bed with a pressure-relieving mattress. On [DATE] at approximately 3:00 p.m., an observation was made of RN (registered nurse) #1 performing wound care to Resident #44's sacral wound. RN #1 stated that they had not seen Resident #44's wound prior to that day and could not speak to how the wound previously looked. RN #1 described Resident #44's wound as a Stage IV (6) pressure ulcer and stated that they had recommended changing the treatment that was in place to the wound. Resident #44's wound was observed to be open, moist with a moderate amount of serosanguineous (7) drainage. A review of Resident #44's Braden Scale Assessment (8) for risk of developing pressure injuries dated [DATE] revealed that they were at very high risk, having scored nine. The progress notes for Resident #44 documented, [DATE] 16:31 (4:31 p.m.) Note Text: Treatment order changed to sacrum area, cleanse with NS (normal saline) apply barrier cream cover with foam dressing q (every) day and prn. Noted area to be 5cmx3cmx0.1cm (5 centimeters length by 3 centimeters width by 0.1 centimeters depth). Resident turned and re-positioned frequently. Review of Resident #44's wound documentation failed to evidence any documentation of a PUSH tool assessment of the sacral pressure injury being completed on [DATE]. The progress notes for Resident #44 documented, [DATE] 16:59 (4:59 p.m.) Late Entry: Note Text: Wound care to sacrum measuring 6.0cm x 3.0 cm x 0.1cm (6 centimeters length by 3 centimeters width by 0.1 centimeters depth). Resident turned and re-positioned frequently. Cleansed with NS apply barrier cream cover with foam dressing daily and prn. Review of Resident #44's wound documentation failed to evidence any documentation of a PUSH tool assessment of the sacral pressure injury being completed on [DATE]. The PUSH tool for Resident #44 documented an assessment of the sacral pressure injury completed on [DATE] with a score of 15. The progress notes for Resident #44 failed to evidence documentation of any assessment such as measurements, description of the wound, completed for the sacral pressure injury on [DATE]. The PUSH tool for Resident #44 documented an assessment of the sacral pressure injury completed on [DATE] with a score of 15. The progress notes for Resident #44 failed to evidence documentation of any assessment such as measurements, description of the wound completed on the sacral pressure injury on [DATE]. The PUSH tool for Resident #44 documented an assessment of the sacral pressure injury completed on [DATE] with a score of 15. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress notes for Resident #44 documented, [DATE] 16:37 (4:37 p.m.) Note Text: L (left) buttock 3.8 cm x 6.0 cm (3.8 centimeters length by 6.0 centimeters width) area with 90% eschar (9) and 10% slough (10) with purulent (containing pus) drainage with foul odor noted. R (right) buttock area 1.5cm x 3cm (1.5 centimeter length by 3 cm width) with slough and purulent drainage noted. The PUSH tool for Resident #44 documented an assessment of the sacral pressure injury completed on [DATE] with a score of 17. The progress notes for Resident #44 failed to evidence documentation of any assessment such as measurements, description of the wound completed for the sacral pressure injury on [DATE]. The progress notes for Resident #44 documented, [DATE] 10:00 (10:00 a.m.) Note Text: Wound rounds completed. Wound bed is 40% granulation tissue (11), 30% slough, and 30% eschar, wound borders are irregular and unattached. A large amount of foul smelling, purulent drainage is noted on the dressing removed. Peri wound (around the wound) is normal skin tissue. Wound care provided according to Physician's orders. Dressing is changed daily and prn until resolved or no longer indicates use of Santyl (wound ointment to remove dead tissue) to wound bed. Review of Resident #44's wound documentation failed to evidence any documentation of a PUSH tool assessment of the sacral pressure injury being completed on [DATE]. The PUSH tool for Resident #44 documented an assessment of the sacral pressure injury completed on [DATE] with a score of 16. The progress notes for Resident #44 documented, [DATE] 04:02 (4:02 a.m.) Note Text: Wound round completed on this Patient. Sacral wound measures (6.8 x 11.8 total affected area) (6.8 length by 11.8 width) 4.0 x 6.0 (center of wound) (4.0 length by 6.0 width) x depth immeasurable due to slough in wound bed, undermining (tunneling) of 3.0 @ 12 (at 12:00 position) is present, slough covering 90% of wound bed is thick, gray [sic], and adherent, 10 % granulation tissue present; borders are irregular and unattached, copious amount of purulent foul odor is present, peri wound is discolored. Continue with current treatment, change daily and prn (as needed) until resolved . The PUSH tool for Resident #44 documented an assessment of the sacral pressure injury completed on [DATE] with a score of 16. The progress notes for Resident #44 documented, [DATE] 06:47 (6:47 a.m.) Note Text: Wound round completed. Sacrum measures 5.8 x 11.8 x immeasurable (5.8 length by 11.8 width by depth), wound bed is 80% gray [sic] slough, 10% granulation tissue, and 10% skin, borders are irregular and unattached, there is a copious amount of foul smelling purulent drainage, peri wound is normal . The PUSH tool for Resident #44 documented an assessment of the sacral pressure injury completed on [DATE] with a score of 16. The progress notes for Resident #44 documented, [DATE] 19:43 (7:43 p.m.) Note Text: Wound care completed. Sacrum measures 5.8 x 5.7 x 4 x 3.5 (5.8 length by 5.7 width by 4 depth by 3.5 undermining). Unstageable. Wound bed is 80% gray slough, 10% granulation tissue, and 10% skin, borders are irregular and unattached, there is a copious amount of serosanguineous drainage, peri wound is normal. Treatment as ordered by Dr (doctor) . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #3 stated the process for a resident on admission is to identify if the resident has any skin integrity issues and to identify the resident's risk for developing a pressure injury. These are done by a Braden scale (to determine risk) and by the admission nursing assessment. If the resident is admitted with pressure injury, the physician is contacted for treatment orders. Additionally, per facility policy, a pressure injury assessment is completed for the resident on admission. She stated if a resident has a pressure injury, he/she is seen weekly during IDT (interdisciplinary team) wound rounds. When asked who composes the IDT team, ASM #3 stated the IDT team includes the DON, unit manager, and wound nurse. ASM #3 stated, They go in every week and look at every wound. She stated someone on the team writes a comprehensive progress note with measurements and a description of the wound. When asked if wound staging is included in the IDT wound rounds each week, ASM #3 stated PUSH tools and staging are used to monitor a wounds progression, healing, or decline. She stated a PUSH tool calculates the size of a wound (surface area) as well as the amount of any material that is coming from the wound (exudate). The PUSH tool also tracks the type of tissue in a wound bed, and uses all of those values to convert the wound to a numerical score. ASM #3 stated this gives a quick look of how the wound is doing. She stated the facility protocol is to develop a PUSH tool for every wound. ASM #3 stated a pressure injury should be assessed weekly. She stated if there is a change in the status of the wound, or something is abnormal, then that should also be documented in a progress note. She stated all pressure injuries and pressure injury treatments should be documented on the resident's care plan. She stated the process is the same for a resident who develops a pressure injury after admission. When asked about the lack of evidence of staging for all wounds, ASM #3 stated there is a deficit in staging in the documentation. She stated weekly wound rounds, PUSH tools, and descriptions could still monitor pressure injuries. A request was made to ASM #3 for any additional documentation for Resident #44's sacral wound. ASM #3 was informed of the concern that Resident #44's clinical record lapsed documentation assessments of the sacral pressure injury other than the progress notes in the clinical record. ASM #3 stated they would provide the PUSH tool assessments for Resident #44's sacral wound. ASM #3 was also informed of the concern that Resident #44's progress notes failed to document any descriptions of the wound or measurements of the pressure injury completed between [DATE] and [DATE] and between [DATE] and [DATE]. On [DATE] at approximately 3:45 p.m., a telephone interview was conducted with ASM #5, medical doctor. ASM #5 stated that long-term care residents received in house wound care. ASM #5 stated that the nurses would assess the wound and notify them. ASM #5 stated that they would assess a pressure ulcer if needed but relied heavily on the wound team for assessments and communication on wound healing and decline. ASM #5 stated that the nurse notified them if a wound appeared infected or needed culture and when the treatment was not working. ASM #5 stated that they were in the facility twice a week and one day was dedicated to new admissions. ASM #5 stated that they mostly rely on the wound care team to assess and inform them of the condition of wounds unless they were requested to assess it. ASM #5 stated that there should be pressure ulcer staging and that most of time there is a diameter and a depth. ASM #5 stated that without staging it was impossible to tell if the wound was getting better or not. ASM #5 stated that residents have their treatments completed prior to them arriving at the facility and they assess the dressing in place over the wound but do not remove the dressing. ASM #5 stated that without staging it was hard to assess a pressure ulcer. (continued on next page)

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Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide foot care and treatment, in accordance with professional standards of practice for one of 25 current residents in the survey sample, Resident #67. The facility staff failed to trim Resident #67's toenails to an optimal length to prevent infection or disease. The findings include: Resident #67 was admitted to the facility on [DATE], and most recently readmitted on [DATE], with diagnoses including ESRD (end stage renal disease) (1), diabetes (2), lymphedema (3), and bipolar disorder (4). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/12/21, Resident #67 was coded as having no cognitive impairment for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff members for personal hygiene. Resident #67 refused to be interviewed regarding her toenails. On 4/21/21 at 2:46 p.m., observation was made of Resident #67's feet. The resident was lying on her back in the bed, and RN (registered nurse) #1 was assessing the resident's feet, and RN #6 was assisting her. Observation revealed Resident #67's right great toenail was at least 1/2 inch beyond her nail bed, thick, with some black areas scattered over the nail. The right third and fourth toenails were at least 1/2 inch beyond the nail bed. The left great toenail and left third toenails were discolored, with some dark areas. The left fourth toenail was at least 1/2 inch beyond the nail bed. RN #6 stated, The nails are definitely too long. They need to be cut. I will have to call the podiatrist. RN #1 stated she thought the doctor needed to look at all the nails because of the nail discolorations on both feet. RN #1 stated there could be a fungal infection or some other process going on. She stated that the toenails were too long, and needed to be cut as soon as possible to promote foot health for Resident #67. A review of Resident #67's comprehensive care plan dated 11/24/20 revealed, in part: ADL (activities of daily living) self care deficit related to physical limitations .Will receive assistance necessary to meet ADL needs .2 staff assistance with ADLS .Assist with daily hygiene, grooming, dressing, oral care, and eating as needed. On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she takes care of Resident #67, she stated she does. When asked if she remembers assessing Resident #67's toenails recently, she stated she could not remember. LPN #2 stated the CNAs (certified nursing assistants) will tell her if a resident's toenails need attention. She stated there is a list on the unit for residents who need a podiatrist to see them. LPN #2 stated she does not think Resident #67 is on that list, but she could be added. When asked if discoloration of a resident's toenails means anything significant, LPN #2 stated it could simply mean the toenails need to be cleaned, or it could mean that the resident has some sort of infection. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/21 at 3:08 p.m., CNA #3 was interviewed. She stated she frequently works with Resident #67, and she looks at the resident's toenails every time I take care of her and bathe her. CNA #3 stated she tries to give the resident a bath every day. CNA #3 stated if she noticed the resident's toenails getting too long, she would tell the nurse. On 4/21/21 at 6:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. A review of the facility policy Foot Care, revealed, in part: Purpose: To stimulate peripheral circulation, control odor, and observe for infection .Patient that is Diabetic .Wash feet daily with mild soap and warm water, do not soak. Dry feet gently and thoroughly, especially between toes .Do not cut toenails (only licensed nurses) .Suggested documentation: Unusual observations and/or complaints and subsequent interventions including communications with physician. No further information was provided prior to exit. REFERENCES (1) End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD). This information is taken from the website https://medlineplus.gov/ency/article/000500.htm. (2) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (3) Lymphedema (LE) is the accumulation of protein-rich fluid in tissues. The impaired function of lymph vessels interrupts the drainage of lymphatic system that is a part of the circulatory system just like the arterial and venous structures. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5508242/#:~:text=Lymphedema%20(LE)%20is%20the%20accumulation,the%20arterial%20and%20venous%20structures. (4) Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks. This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview and facility document review, it was determined the facility staff failed to provide services to prevent a decrease in range of motion (ROM) for one of 25 current residents in the survey sample, Resident #24. The facility failed to provide ROM services after identification of weakness and impaired mobility on admission for Resident #24. The findings include: Resident #24 was admitted to the facility on [DATE]. Resident #24's diagnoses included but were not limited to: anoxic brain injury (irreversible damage to the brain caused by a lack of oxygen) (1), seizures (a sudden, involuntary and violent contraction of a group of muscles, sometimes with loss of consciousness) (2) and tracheostomy (a surgically created opening into the trachea, with a tube inserted to establish an airway) (3). Resident #24's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/13/21, coded the resident as scoring 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G-Functional Status: coded the resident as dependent with bed mobility, transfers, dressing, eating, personal hygiene and bathing; walking and locomotion did not occur. A review of MDS Section O- Special treatments, procedures and programs: coded the resident as tracheostomy 'yes' and oxygen therapy 'yes'. A review of the admission evaluation dated 2/6/21, documented in part, Clinical evaluation-neurological: identify areas of weakness- right upper extremity, left upper extremity, right lower extremity, left lower extremity, (all four areas checked). Clinical evaluation-musculoskeletal: upper extremity range of motion-impairment on both sides, lower extremity range of motion-impairment on both sides. Trigger for baseline care plan: Alteration in musculoskeletal status. The resident's mobility will be improved/restored by use of (specify: prosthesis, use of adaptive equipment). A review of the medical practitioner full assessment dated [DATE], documented in part, Musculoskeletal decreased ROM and weakness-atrophy or spasticity were checked. Abnormal findings documented-contracture of right hand. A review of Resident #24's comprehensive care plan dated 2/6/21, with a revised on date of 2/19/21, revealed Range of Motion was not identified as a focus on the comprehensive care plan provided. An interview was conducted on 4/20/21 at 2:00 PM with CNA (certified nursing assistant) #1. When asked when ROM was performed for Resident #24, CNA #1 stated, When morning care is provided, we do it then. When asked if this is documented anywhere, CNA #1 stated, No, it is not. When asked about devices to prevent further contracture of Resident #24's right hand, CNA #1 stated, We sometimes put a rolled up washcloth in their hand to help with contracture. When asked where the device was on 4/20/21 at 2:00 PM, CNA #1 stated, It's not there. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/21/21 at 8:53 AM with LPN (licensed practical nurse) #1. When asked the purpose of ROM, LPN #1 stated, ROM is to prevent weakness and stiffening of muscles and joints. When asked what devices are used with hand contractures, LPN #1 stated, We use a carrot or rolled up washcloth. She doesn't have one; I will get it for her. An observation was made on 4/21/21 at 4:20 PM, no carrot or rolled up washcloth was in Resident #24's right hand, a rolled up hand towel was in place in the bend of both elbows. An observation was made on 4/22/21 at 8:10 AM, no carrot or rolled up washcloth was in Resident #24's right hand, a rolled up hand towel was in place in the bend of both elbows. An interview was conducted on 4/22/21 at 8:17 AM with RN (registered nurse) #3, the unit manager. When asked the purpose of providing ROM, RN #3 stated, We provide ROM to those residents who are not mobile and need ROM to keep their muscles and joints mobile and reduce the chance of contractures. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concern on 4/22/21 at 5:20 PM. The facility's Range of Motion: Active/Passive policy revised 2/2019, documents in part, Purpose: To improve or maintain joint mobility and minimize potential for contractures. Suggested documentation: care provided in plan of care. Document in progress notes if unusual observations and/or complaints and subsequent interventions including communications with medical practitioner or rehabilitation therapist as clinically indicated. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 37. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 137. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 574.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility failed to provide services related to a urinary catheter for one of 25 current residents in the survey sample, Resident #25. The facility failed to monitor and record urinary output amounts on multiple dates since the resident's admission on 2/9/21. The facility failed to evidence Foley catheter care on multiple dates since the resident's admission on 2/9/21. The findings include: Resident #25 was admitted to the facility on [DATE] with diagnoses including epilepsy, COPD (chronic obstructive pulmonary disease) (1), and diabetes (2). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/16/21, Resident #25 was coded as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). Resident #25 was coded as being totally dependent on the assistance of staff members for all activities of daily living. He was coded as having a Foley catheter (3) in place. Resident #25 declined to be interviewed during the survey. On the following dates and times, 4/20/21 at 11:40 a.m., 4/20/21 at 12:47 p.m., 4/20/21 at 1:48 p.m., and 4/21/20 at 9:11 a.m., Resident #25 was observed lying on his back in bed. At all observations, a Foley catheter collection bag, contained in a privacy cover, was hanging on the bed frame. The catheter was observed draining light yellow urine. A review of Resident #25's admission nursing assessment dated [DATE] revealed documentation confirming Resident #25 had a Foley catheter in place on admission. A review of Resident #25's physicians' orders revealed the following order, dated 3/6/21: Foley output every shift for monitoring purpose. There was no order for urinary output monitoring prior to 3/6/21. A review of Resident #25's TARs (treatment administration records) revealed no documentation for urinary output on the following dates and times: 3/9/21 night shift, 3/11/21 day shift, 3/13/21 day shift, 3/23/21 day shift, 3/25/21 day shift, 3/27/21 day and evening shifts, 3/28/21 evening and night shifts, 3/30/21 evening shift, 4/2/21 evening shift, 4/4/21 day and evening shifts, 4/7/21 day shift, 4/10/21 day shift, 4/11/21 day shift, 4/17/21 day shift. A review of Resident #25's physicians' orders revealed the following order, dated 3/4/21: Foley catheter care q (every) shift. A review of Resident #25's TARs revealed no documentation related to Foley catheter care for any shift between 2/9/21 and 3/4/21. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #25's clinical record revealed the following physician order, dated 3/24/21: Levofloxacin Tablet (5) 250 mg give one tablet via PEG (percutaneous endoscopic gastrostomy) tube (4) one time a day for UTI (urinary tract infection). A review of Resident #25's comprehensive care plan dated 2/22/21 revealed no information related to the resident's Foley catheter. On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she takes care of Resident #25 regularly, she stated she does. When asked if it is important to monitor Resident #25's urine output, she stated it is important in order to make sure the resident is not retaining fluid. LPN #2 stated the resident receives tube feedings, and the nurses need to make sure he is putting out a moderate amount of fluid. She stated she checks on the resident periodically throughout her shift to make sure the resident's Foley catheter is draining, and the CNAs (certified nursing assistants) give the total amount of urine output at the end of each shift. When asked if it is possible to monitor a resident's urinary output across days if there is no specific amount of output documented in the record, LPN #2 stated there is not. On 4/21/21 at 3:08 p.m., CNA #3 was interviewed. When asked about the process used for tracking a resident's urine output, CNA #3 stated she totals the output at the end of the shift when she empties the urine collection bag, and she reports the amount to the nurse. On 4/22/21 at 5:17 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. Policies related to Foley catheter care and monitoring urinary output were requested. On 4/23/21 at 10:08 a.m., ASM #3 stated there is no evidence Foley catheter care was provided to Resident #25 prior to 3/6/21. ASM #3 stated the facility's standard is not to monitory urinary output for a resident who has a Foley catheter unless a physician orders it. She stated the facility does not have a policy related to urinary output. A review of the facility policy, Catheter Care: Indwelling Catheter, revealed, in part, the following: Purpose: To provide hygiene for patients with indwelling catheters. No further information was provided prior to exit. REFERENCES (1) COPD is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and [NAME], page 124. (2) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (3) A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder. This information is taken from the website https://medlineplus.gov/ency/article/003981.htm. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(4) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm (5) Levofloxacin (Levaquin) is used to treat certain infections such as pneumonia, and kidney, prostate (a male reproductive gland), and skin infections. Levofloxacin is also used to prevent anthrax (a serious infection that may be spread on purpose as part of a bioterror attack) in people who may have been exposed to anthrax germs in the air, and treat and prevent plague (a serious infection that may be spread on purpose as part of a bioterror attack. Levofloxacin may also be used to treat bronchitis, sinus infections, or urinary tract infections but should not be used for bronchitis and certain types of urinary tract infections if there are other treatment options available. Levofloxacin is in a class of antibiotics called fluoroquinolones. It works by killing bacteria that cause infections. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697040.html.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to address a significant weight gain for one of 25 residents in the survey sample, Resident #19. The facility staff failed to address Resident #19's monthly weight gain of 11.10 percent in March 2021. The findings include: Resident #19 was admitted to the facility on [DATE]. Resident #19's diagnoses included but were not limited to end stage renal disease, diabetes and muscle weakness. Resident #19's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/7/21 coded the resident as being cognitively intact. Review of Resident #19's clinical record revealed a weight of 219 pounds on 2/2/21 and a weight of 243.3 pounds on 3/16/21 (totaling 11.10 percent gain). Further review of Resident #19's clinical record including nurses' notes, dietary notes and nutritional assessments failed to reveal the 11.10 percent gain on 3/16/21 was addressed. Resident #19's comprehensive care plan dated 2/5/21 documented, Resident is at risk for alterations in nutritional / hydration status related to ESRD- HD (end stage renal disease- hemodialysis), DM2 (diabetes), therapeutic diet, impaired mobility, prefers eating all meals each day from an outside source via delivery. The former RD (registered dietician) was no longer employed at the facility. On 4/21/21 at 2:41 p.m., an interview was conducted with OSM (other staff member) #5 (the current RD). OSM #5 stated residents should be weighed every month unless specified and he will be reviewing residents' weights every month. OSM #5 stated that if he notes a weight gain of five percent or more in a month then he asks for the resident to be re-weighed, then goes through a process of elimination to try to determine the cause of the weight gain. OSM #5 stated that after he identifies the potential cause then he implements interventions to address the gain. On 4/21/21 at 6:08 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility policy regarding weight measurement documented, WEIGHT CHANGE FOLLOW-UP AND DOCUMENTATION -Identify the change on the Daily Interdisciplinary Eagle Room Report (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Enter significant weight changes on the Weight Change Eagle Room tool. Use the Acute Condition Change Eagle Room tool for weekly weight changes that need follow-up. -Notify the physician and responsible party. -Consider scheduling for weekly weights until resolved. Registered dietician evaluates and documents in the nutrition progress notes. No further information was presented prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services for seven of 25 residents in the survey sample, Residents #61, #3, #44, #35, #11, #24 and #25. The facility staff failed to administer a CPAP (1) machine per physician's order to Resident #61, failed to provide oxygen at the prescribed rate to Residents #61, #3, #11, and #24. The staff failed to ensure tracheostomy care was provided as ordered by the physician to Resident #24 on 4/12/21, 4/13/21 and 4/16/21 day shift, and to Resident #25 from 2/9/21 through 3/3/21 and, failed to ensure Resident #44's tracheostomy mask, tubing and humidifier bottle were dated to determine when the tubing needed to be changed, failed provide respiratory services in a sanitary manner for Resident #35, the residents tracheostomy collar mask was observed undated, hanging on the humidifier bottle of the machine uncovered, and staff failed to ensure an ambu bag was at the bedside for Resident # 24, #44 and #35, as per the facility policy for a resident with a tracheostomy. The findings include: 1.a. The facility staff failed to administer a CPAP (1) machine per physician's order to Resident #61. Resident #61 was admitted to the facility on [DATE]. Resident #61's diagnoses included but were not limited to chronic obstructive pulmonary disease (lung disease), congestive heart failure and sleep apnea (2). Resident #61's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/30/21, coded the resident as being cognitively intact. Section G coded Resident #61 as requiring extensive assistance of two or more staff with bed mobility. Review of Resident #61's clinical record revealed a physician's order dated 3/25/21 to apply CPAP at bedtime for sleep apnea. Review of multiple nurses' notes from Resident #61's admitted revealed a CPAP machine was not available. Resident #61's comprehensive care plan dated 4/5/21 documented, Has/At risk for respiratory impairment related to COPD (chronic obstructive pulmonary disease), sleep apnea. Administer medications/treatments per physician orders . On 4/21/21 at 9:09 a.m., an interview was conducted with Resident #61. Resident #61 stated she uses a CPAP but she is not currently using one because she did not bring one from home. When asked if the facility had provided a CPAP, Resident #61 stated she was not saying. On 4/21/21 at 5:02 p.m., an interview was conducted with LPN (licensed practical nurse) #3, a nurse who cared for Resident #61. LPN #3 stated a CPAP was not being used for Resident #61 because the resident's family brought in an older CPAP but the facility did not have the supplies for it, nor would she know how to operate it. LPN #3 stated she reported this to the former director of nursing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/21 at 6:10 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. ASM #3 stated the facility could provide a CPAP. The facility policy regarding CPAP machines documented, Note: the majority of patients will bring their CPAP machine from home. Manufacturer's recommendations should be followed. If there are any questions, a sticker on the machine usually identifies the company where the patient either purchased or rented the machine. Note: Patient's note bring their machine from home should be set up by respiratory therapy, a DME (durable medical equipment) company, or a trained licensed nurse . References: (1) Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm (2) Sleep apnea causes your breathing to stop or get very shallow. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=sleep+apnea&_ga=2.179275620.1120921071.1619453033-1457724988.1619453033 1.b. The facility staff failed to administer oxygen to Resident #61 at the physician prescribed rate of three liters per minute. Review of Resident #61's clinical record revealed a physician's order dated 3/24/21 for oxygen at three liters continuously via nasal cannula every day shift and every evening shift. On 4/20/21 at 11:35 a.m. and 4/20/21 at 2:05 p.m., Resident #61 was observed lying in bed receiving oxygen via nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate between three and a half and four liters as evidenced by the center of the ball in the concentrator flow meter positioned between the three and a half and four liter lines. Resident #61's comprehensive care plan dated 4/5/21 documented, Has/At risk for respiratory impairment related to COPD (chronic obstructive pulmonary disease), sleep apnea. Administer medications/treatments per physician orders . On 4/21/21 at 5:02 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for three liters of oxygen. LPN #3 stated the middle of the ball in the flow meter should be on the three liter line. On 4/21/21 at 6:10 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The oxygen concentrator manufacturer's manual documented, Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liters per minute) line prescribed. The facility policy regarding oxygen administration documented, 3. For oxygen concentrator, plug in power cord, turn unit on and set flow meter to correct flow rate . No further information was presented prior to exit. 42106 2. The facility staff failed to provide oxygen at the prescribed rate to Resident #3. Resident #3 was admitted to the facility with diagnoses that included but were not limited to heart failure (1) and cardiomyopathy (2). Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 1/15/21 coded Resident #3 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section O coded Resident #35 receiving oxygen while a resident at the facility. On 4/20/21 at approximately 10:50 a.m., an interview was conducted with Resident #3 in their room. Resident #3 was observed lying in bed wearing a nasal cannula that was connected to an oxygen concentrator that was observed to the right of Resident #3 beside their bed. The oxygen concentrator flowmeter was observed set at 4 liters. Resident #3 stated that they wore the oxygen all the time at 4 liters. Resident #3 stated that they had problems with being able to feel the oxygen flow from the concentrator and the nurses would adjust it when needed. When Resident #3 was asked if they ever adjusted the oxygen flow themselves, Resident #3 laughed and stated, I do not have a right arm and I am bed ridden. I cannot reach the machine even if I wanted to. I have to call them to come and turn it up when I can't feel it. On 4/20/21 at approximately 11:00 a.m., Resident #3 was observed leaving the facility on a stretcher wearing portable oxygen. Observation of the oxygen concentrator in Resident #3's room revealed it was off. On 4/20/21 at approximately 1:30 p.m., Resident #3 was observed back in their room, with a nasal cannula in place connected to the oxygen concentrator. Observation of the oxygen concentrator flowmeter revealed the oxygen flow rate was set at 4 liters. Additional observations on 4/21/21 at 9:10 a.m. and 3:30 p.m., of Resident #3's oxygen flowrate revealed the same findings as above. The physician orders for Resident #3 documented in part, .O2 (oxygen) @ (at) 2 (two) liters per minute via nasal cannula every shift for supplemental oxygen. Order Date: 02/02/2021 . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan for Resident #3 dated 5/20/2015 documented in part, Resistive/non-compliant with treatment/care related to : refusing showers, getting out of bed says he has been in bed for years and not changing now, refusing meds (medications), removes oxygen, refuses vital signs and therapy, refuses non-pharmacological interventions prior to PRN (as needed) medications, consistently in positions that can contribute to skin breakdown, stating he is going to remove life vest (3). Date Initiated: 05/20/2015. Revision on: 09/18/2020. It further documented, Cardiac disease related to Hypertension (high blood pressure), cardiomyopathy, CHF (congestive heart failure). Date Initiated: 03/17/2016. Under Interventions it documented in part, .O2 as ordered, encourage resident to keep oxygen tubing on and notify nurse if resident will not keep oxygen on. Date Initiated: 09/19/2018. Revision on 03/24/2020 .Administer medication per physician orders. Date Initiated: 03/17/2016 . On 4/22/21 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that the oxygen flow rate was checked at least every shift but should be checked each time the nurse enters the room. LPN #8 stated that the ball on the flowmeter of the concentrator should be centered on the line of the oxygen setting. On 4/22/21 at approximately 8:15 a.m., LPN #8 observed Resident #3's oxygen which was set at 2 liters. Resident #3 stated that a nurse who he did not know came in a few minutes before and changed the oxygen to 2 liters. Resident #3 stated that they could not feel any oxygen coming out of the cannula now and felt like they were not getting any oxygen. LPN #8 advised Resident #3 that they had set the oxygen to the rate the physician ordered this morning and they were contacting their physician to have the order changed to increase the oxygen to 4 liters. The facility policy Oxygen Administration dated Updated: 07/2017, documented in part, .Application of Nasal cannula: .5. Set flow rate . The manufacturer's instructions for use provided by the facility for the oxygen concentrator used by Resident #3 documented in part, .Warning. Do not change the L/min (liters per minute) setting on the flowmeter unless a change has been prescribed by your physician or therapist. Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed . On 4/22/21 at approximately 9:45 a.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. On 4/22/21 at approximately 5:00 p.m., ASM #3, the quality consultant stated that staff reported to them that Resident #3 had adjusted the oxygen themselves this morning after they changed it to 2 liters and they had been educated to not adjust the oxygen themselves and updated their care plan. When informed that the resident was asked if he adjusted the oxygen and the resident stated he does not have a right arm and is bed ridden and cannot reach the machine even if he wanted to. ASM stated that's what the staff reported to me. No further information was provided prior to exit. Reference: (1). Heart failure (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (2). Cardiomyopathy Disease in which the heart muscle becomes weakened, stretched, or has another structural problem. It often occurs when the heart cannot pump or function well. Most people with cardiomyopathy have heart failure. This information was obtained from the website: https://medlineplus.gov/ency/article/001105.htm. (3). Life vest The LifeVest(R) wearable cardioverter defibrillator (WCD) is designed to protect patients at risk of sudden cardiac death (SCD), when a patient's condition is changing and permanent SCD risk has not been established. This information was obtained from the website: https://lifevest.[NAME].com/ 3. During separate observations, Resident #44's tracheostomy mask, tubing and humidifier bottle were observed undated and there was no ambu bag was observed in Resident #44's room per the facility policy for a resident with a trachesotomy. Resident #44 was admitted to the facility with diagnoses that included but were not limited to nontraumatic intracerebral hemorrhage (1) and tracheostomy (2). Resident #44's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 3/12/21 coded Resident #44 as being non-verbal and severely impaired of making daily decisions. Section G coded Resident #44 as totally dependent on two or more staff members for bed mobility, dressing and toileting and totally dependent on one staff member for eating and personal hygiene. Section O coded Resident #44 receiving oxygen, suctioning and tracheostomy care while a resident at the facility. The physician orders for Resident #44 documented in part, .Cool air mist via trach collar (oxygen mask) continuous with O2 (oxygen) titrated in at 5 liters every shift for respiratory failure. (3) Order Date: 12/03/2020 . PRN (as needed) as needed for trach [tracheostomy] care. Order Date: 05/28/2020 . The comprehensive care plan for Resident #44 dated 12/15/2020 documented in part, Has/At risk for respiratory impairment related to tracheostomy. Date Initiated: 12/15/2020. Revision on: 03/16/2021. Under Interventions it documented in part, .Administer oxygen as per physician order: 5 L (liter) via cool mist humidifier. Date Initiated: 12/15/2020 .Maintain replacement trach tube and Ambu bag (4) at bedside. Date Initiated: 12/15/2020 . On 4/20/21 at approximately 10:45 a.m., an observation was conducted of Resident #44 in their room. Resident #44 was observed in bed and was observed with a tracheostomy. Resident #44 was observed wearing a tracheostomy mask (oxygen delivery device) delivering oxygen at 5 lpm (liters per minute). The humidifier bottle attached to the oxygen tubing was observed empty. The tracheostomy mask, tubing and humidifier bottle were observed undated. No ambu bag was observed in Resident #44's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional observations on 4/20/21 at 1:34 p.m. revealed the findings as above. On 4/21/21 at approximately 9:30 a.m., the humidifier bottle attached to the oxygen tubing delivering oxygen to Resident #44 was observed half full. The tracheostomy mask, tubing and bottle remained undated. No ambu bag was observed in Resident #44's room. On 4/21/21 at approximately 3:15 p.m., an interview was conducted with RN (registered nurse) #6, the unit manager. RN #6 stated that ambu bags were kept on the emergency cart at the nurse's station and were not kept in Resident #44's room. RN #6 stated that if Resident #44's tracheostomy became dislodged or removed accidentally they would go to the supply closet to obtain another tracheostomy and to the emergency cart to get the ambu bag. RN #6 stated that the only emergency supplies kept in Resident #44's room were suction equipment, suction catheters and the tracheostomy cleaning kit and proceeded to point out where they were kept in Resident #44's room. RN #6 stated that they did not keep ambu bags in any resident rooms in the facility. On 4/22/21 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that oxygen supplies were changed weekly and were dated when put into use. LPN #8 stated that they were supposed to keep suction equipment, extra tracheostomy tubes and ambu bags in the rooms of residents with a tracheostomy. LPN #8 observed Resident #44's room and stated that there were extra tracheostomy inner cannulas in the wardrobe drawer along with suction catheters and tracheostomy cleaning kits but there was no ambu bag. LPN #8 stated that there was no date on the oxygen mask, tubing or bottle. LPN #8 stated that the ambu bag was located on the emergency cart at the nurse's station. The facility policy Oxygen Administration dated updated: 07/2017 documented in part, .Change all tubing and masks as per state protocol and label with date and initials . The facility policy Tracheostomy Care dated updated 07/2017 documented in part, .Note: A spare tracheostomy tube of the same size and type should be kept at the patient's bedside for emergency purposes. An Ambu-bag should also be kept at the patient's bedside with attachment to fit trach . On 4/22/21 at approximately 9:45 a.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. Reference: (1). Intracerebral hemorrhage Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm. (2). Tracheostomy A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3). Respiratory failure When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (4). Ambu bag A self-refilling bag-valve-mask unit with a 1-1.5 litre capacity, used for artificial respiration which, while suboptimal for the non-intubated patient, is effective for ventilating and oxygenating intubated patients, allowing both spontaneous and artificial respiration. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/Ambu+bag 4. The facility staff failed to provide respiratory services in a sanitary manner for Resident #35. During [NAME] observations, Resident #35's tracheostomy collar mask was observed hanging on the humidifier bottle of the machine uncovered. There was no date observed on the mask and mask tubing and there was no ambu bag observed in Resident #35's room per the facility policy for a resident with a tracheostomy. Resident #35 was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm of base of tongue (1) and tracheostomy (2). Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 3/3/21 coded Resident #35 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Section O coded Resident #35 receiving suctioning and tracheostomy care while a resident at the facility. The comprehensive care plan for Resident #35 dated 5/29/2020 documented in part, Has/At risk for respiratory impairment related to tracheostomy secondary to tongue malignancy. Date Initiated: 05/29/2020. Revision on: 05/29/2020. Under Interventions it documented in part, .treatments per md (medical doctor) orderers [sic] Date Initiated: 05/29/2020 . Administer medications/treatments per physicians orders. Date Initiated: 05/29/2020 .Maintain replacement trach [tracheostomy] tube and Ambu bag (3) at bedside. Date Initiated: 12/15/2020 . The physician orders for Resident #35 documented in part, .Cool air mist via trach collar (oxygen mask) PRN (as needed) as needed for trach care. Order Date: 05/28/2020 . The eMAR (electronic medication administration record) and eTAR (electronic treatment administration record) dated 4/1/2021-4/30/2021 for Resident #35 failed to evidence documentation of the cool air mist via trach collar as needed or cleaning or replacement of the trach collar. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/21 at approximately 10:30 a.m., an observation was conducted of Resident #35 in their room. Resident #35 was observed sitting on the side of their bed wrapping a compression bandage around their knee. Resident #35 was observed with a tracheostomy in place. Resident #35 was observed to have a humidifier machine and suction machine on their nightstand beside the bed. A tracheostomy collar mask was observed hanging on the humidifier bottle of the machine uncovered. The mask was observed to contain visible debris. There was no date observed on the mask and mask tubing. When asked if they used the humidifier and mask, Resident #35 nodded and stated Yes. When asked if the staff kept the water in the bottle and took care of the mask, Resident #35 nodded again and stated Yes. Resident #35 stated that they wore the mask at night. There was no ambu bag observed in Resident #35's room. Additional observations on 4/20/21 at 1:45 p.m. revealed the same findings as above. On 4/21/21 at approximately 10:30 a.m. and 3:15 p.m., observations of Resident #35's room revealed the mask hanging on the humidifier bottle attached to the machine uncovered but no visible debris on the mask. The tracheostomy mask, tubing and bottle remained undated and observations failed to reveal an ambu bag in Resident #35's room. On 4/21/21 at approximately 3:15 p.m., an interview was conducted with RN (registered nurse) #6, the unit manager. RN #6 stated that ambu bags were kept on the emergency cart at the nurse's station and were not kept in any resident rooms. On 4/22/21 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that oxygen supplies were changed weekly and were dated when put into use. LPN #8 stated that masks were stored in plastic bags that were dated when not in use. LPN #8 stated that they were stored in the bags to keep them clean. LPN #8 observed Resident #35's room and stated that Resident #35 managed applying their humidifier mask themselves and removed it themselves so that was why it was left hanging on the bottle. LPN #8 stated that it should have had a date on it and should be changed weekly. LPN #8 stated that the staff should still monitor Resident #35 when they are applying and removing their mask to ensure that it is kept clean and changed weekly. LPN #8 stated there was no bag in Resident #35's room for their mask because they managed it themselves. LPN #8 stated that it should be on their care plan if the resident self managed their treatment and did not comply with storage of the mask. LPN #8 asked Resident #35 if they wore their humidifier mask the previous night and Resident #35 stated, Yes. LPN #8 stated that they were going to obtain a new mask and tubing and date them so they would know when they needed to be changed. LPN #8 stated that an ambu bag needed to be placed in Resident #35's room. The facility policy Oxygen Administration dated updated: 07/2017 documented in part, .When oxygen not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag .Change all tubing and masks as per state protocol and label with date and initials . On 4/22/21 at approximately 9:45 a.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. Reference: (1). Malignant neoplasm (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The term malignancy refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. (2). Tracheostomy A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (3). Ambu bag A self-refilling bag-valve-mask unit with a 1-1.5 liter capacity, used for artificial respiration which, while suboptimal for the non-intubated patient, is effective for ventilating and oxygenating intubated patients, allowing both spontaneous and artificial respiration. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/Ambu+bag 29125 5. The facility staff failed to administer oxygen at the physician ordered rate for Resident #11. Resident #11 was admitted to the facility on [DATE] with the diagnoses of but not limited to multiple sclerosis, dysphagia, chronic obstructive pulmonary disease (COPD), dementia, depression, anxiety disorder, hypothyroidism, and high blood pressure. The most recent MDS (Minimum Data Set) assessment, a quarterly assessment with an ARD (Assessment Reference Date) of 1/27/21, coded Resident #11 as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, except for eating which coded the resident as requiring extensive assistance. A review of the clinical record revealed a physician's order for Resident #11 dated 2/2/21 for O2 (oxygen) @ (at) 3l/min (three liters per minute) via NC (nasal cannula) every shift for supplemental oxygen. Observations of Resident #11 on 4/20/21 at 2:50 PM, 4/21/21 at 8:44 AM, 4/21/21 at 9:42 AM, and 4/21/21 at 2:27 PM, revealed the resident in bed with her nasal cannula on, connected to an oxygen concentrator. The oxygen rate on the oxygen concentrator flowmeter was set at 2 liters per minute as evidenced by the flowmeter ball centered on the line for the 2 liter mark. On 4/21/21 at 2:27 PM in an interview with RN #4 (Registered Nurse), the resident's nurse, RN #4 stated the oxygen flow rate should be 2 liters. When asked to verify the order, RN #4 checked and stated, It should be 3 liters. She then checked the resident's oxygen concentrator and stated that the rate was set at 2 liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan revealed one dated 3/19/12 for Has respiratory impairment r/t (related to) COPD. This care plan contained an intervention dated 7/10/15 for administer oxygen per physician orders. According to Fundamentals of Nursing, 6th edition, [NAME] and [NAME], 2005, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity ([NAME], 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration. On 4/21/21 at 6:00 PM at the end of day meeting, ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. 42183 6. The facility failed to provide oxygen at the physician prescribed flow rate for Resident #24 and failed to ensure tracheostomy care was provided as ordered by the physician on 4/12/21, 4/13/21 and 4/16/21 day shift and failed to ensure an ambu bag was present at Resident #24's bedside per the facility policy. Resident #24 was admitted to the facility on [DATE]. Resident #24's diagnoses included but were not limited to: anoxic brain injury (irreversible damage to the brain caused by a lack of oxygen) (1), seizures (a sudden, involuntary and violent contraction of a group of muscles, sometimes with loss of consciousness) (2) and tracheostomy (a surgically created opening into the trachea, with a tube inserted to establish an airway) (3). Resident #24's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/13/21, coded the resident as scoring 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G-Functional Status: coded the resident as dependent with bed mobility, transfers, dressing, eating, personal hygiene and bathing; walking and locomotion did not occur. A review of MDS Section O- Special treatments, procedures and programs: coded the resident as tracheostomy 'yes' and oxygen therapy 'yes'. During initial resident observation on 4/20/21 at 10:35 AM, observation revealed Resident #24 with tracheostomy [trach] and receiving O2 via concentrator. Resident #24's O2 (oxygen) setting on the oxygen concentrator flowmeter was observed at 4.5 liters per minute. No ambu-bag or replacement trach was observed at bedside. On 4/20/21 at 2:49 PM, Resident #24's O2 setting on the oxygen concentrator flow meter was observed at 4. 5 liters per minute. No ambu-bag or replacement trach was observed at bedside. On 4/21/21 at 8:53 AM, Resident #24's O2 setting on the oxygen concentrator flow meter was observed at 4. 5 liters per minute and verified by LPN (licensed practical nurse) #1. When asked the setting, LPN #1 stated, It is at 4.5 liters per minute and should be at 5 liters per minute. I'll set it to 5 liters per minute now. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #24's comprehensive care plan dated 2/6/21 and revised on 2/19/21, fails to evidence documentation of trach care. Comprehensive care plan, documents in part, FOCUS-The resident has altered respiratory status/difficulty breathing related to tracheostomy status. INTERVENTIONS-Administer medications as ordered elevate head of bed 30 degrees, monitor changes in orientation, anxiety and air hunger. Monitor for signs and symptoms of respiratory distress and report to physician. Monitor and report abnormal breathing patterns to physician. Position resident with proper body alignment for optimal breathing pattern. A review of the physician orders dated 2/6/21, documented in part, Suction as needed to maintain patent airway and every shift. Trach care daily and as needed. Remove disposable and dispose of inner cannula. Replace with new inner cannula as needed to reduce the risk of infection. A review of the admission evaluation dated 2/6/21, documented in part, Clinical evaluation respiratory: special treatments and procedures- oxygen therapy, tracheostomy and suctioning all were checked. A review of the medical practitioner full assessment dated [DATE], documented in part, Trach placement 12/30/20. Diagnosis 1: acute respiratory failure, anoxic brain damage. Diagnosis 1 plan: O2 (oxygen) at 5 liters per minute via trach. Suction as needed and every shift to maintain patent airway. Trach care daily and as needed to remove and dispose of inner cannula. Replace with new inner cannula one time a day to reduce risk of infection. A review of the April TAR (treatment administration record), documented in part, Trach care daily and as needed. Remove and dispose of inner cannula and replace with new inner cannula one time a day to r [TRUNCATED]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide dialysis services for two of 25 residents in the survey sample, (Residents #19 and #67). 1. The facility staff failed to ensure communication regarding Resident #19's care with the dialysis center, failed to assess the resident's dialysis access site per physician's order, failed to follow up on a fluid restriction recommendation from Resident #19's dialysis RD (registered dietician). 2. For Resident #67, the facility staff failed to obtain a physician's order for dialysis (1), failed to follow a physician's order for fluid restriction, failed to evidence documentation of assessment of her dialysis access site, and failed to maintain communication with the dialysis center. The findings include: 1.a. The facility staff failed to ensure communication regarding Resident #19's care with the dialysis center. Resident #19 was admitted to the facility on [DATE]. Resident #19's diagnoses included but were not limited to end stage renal disease, diabetes and muscle weakness. Resident #19's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/7/21 coded the resident as being cognitively intact. Review of Resident #19's clinical record revealed a physician's order dated 4/12/21 for dialysis every Monday, Wednesday and Friday. Resident #19's comprehensive care plan dated 2/11/21 documented, Renal insufficiencies related to: chronic renal failure with anemia. Coordinate dialysis care with dialysis treatment center . Further review of Resident #19's clinical record failed to reveal any documented communication between the facility staff and dialysis center staff. A dialysis communication book labeled with Resident #19's name contained the resident's face sheet, physician order sheet and four blank dialysis communication forms. On 4/20/21 at 1:44 p.m., an interview was conducted with Resident #19. The resident stated she had not seen a dialysis communication book since she was admitted to the facility. On 4/21/21 at 2:57 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses are supposed to document residents' pre-dialysis vital signs in residents' dialysis communication books and send the books to the dialysis center. LPN #2 stated communication with the dialysis center is important because the facility nurses want to know what was done at the dialysis center. LPN #2 stated she would call the dialysis center if residents returned from dialysis without documented information. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/21 at 6:08 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility dialysis guidelines documented Both the center and the dialysis facility are responsible for shared communication regarding patients receiving dialysis services, either onsite or offsite. The Hemodialysis Communication Form is to be used . No further information was presented prior to exit. 1.b. The facility staff failed to assess Resident #19's dialysis access site per physician's order. Review of Resident #19's clinical record revealed a physician's order dated 2/1/21 to check the AV (arteriovenous) fistula site (1) thrill (vibration) and bruit (buzzing) every shift. Review of TARs (treatment administration records) for February 2021 through April 2021 failed to reveal evidence that the thrill and bruit was checked as evidenced by blank spaces of the TARs, on the following dates: 2/7/21 at 11:15 (a.m. or p.m. was not specified) 2/9/21 at 3:15 p.m. 2/12/21 at 7:15 a.m. 2/13/21 at 3:15 p.m. 3/2/21 at 7:15 a.m. 3/7/21 at 3:15 p.m. 3/9/21 at 7:15 a.m. and 3:15 p.m. 3/11/21 at 7:15 a.m. 3/13/21 at 3:15 p.m. 3/14/21 at 3:15 p.m. 3/15/21 at 7:15 a.m. and 3:15 p.m. 3/16/21 at 7:15 a.m. and 3:15 p.m. 3/17/21 at 7:15 a.m. 3/18/21 at 3:15 p.m. and 11:15 (a.m. or p.m. was not specified) 3/23/21 at 3:15 p.m. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/25/21 at 3:15 p.m. 3/26/21 at 7:15 a.m. and 3:15 p.m. 3/31/21 at 3:15 p.m. 4/1/21 at 7:15 a.m. 4/11/21 at 3:15 p.m. 4/13/21 at 7:15 a.m. Review of nurse's notes for the above dates only revealed documentation of assessment of Resident #19's thrill and bruit on 2/13/21 at 2:28 a.m., 3/2/21 at 9:21 p.m., 3/17/21 at 11:29 p.m. and 3/25/21 at 11:03 p.m. Resident #19's comprehensive care plan dated 2/11/21 documented, Renal insufficiencies related to: chronic renal failure with anemia. Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to physician . On 4/20/21 at 1:44 p.m., an interview was conducted with Resident #19. Resident #19 stated the nurses only check her AV fistula for thrill and bruit every once in a while. On 4/21/21 at 5:02 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated you can't say a treatment was done if it is not signed off on the TAR. LPN #3 stated she was told that if it wasn't documented, it wasn't done. On 4/21/21 at 6:08 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility guidelines regarding assessment of AV shunts, fistulas and grafts documented, The evaluation of arteriovenous shunts, fistulas, and grafts by a licensed nurse is intended to facilitate early detection of potential complications which includes signs and symptoms of infection, leakage, and thrombosis. Any abnormal signs and symptoms should be reported to the physician .Document completion of observation or assessment on TAR . No further information was presented prior to exit. Reference: (1) The best type of long-term access is an AV fistula. A surgeon connects an artery to a vein, usually in your arm, to create an AV fistula. An artery is a blood vessel that carries blood away from your heart. A vein is a blood vessel that carries blood back toward your heart. When the surgeon connects an artery to a vein, the vein grows wider and thicker, making it easier to place the needles for dialysis. The AV fistula also has a large diameter that allows your blood to flow out and back into your body quickly. The goal is to allow high blood flow so that the largest amount of blood can pass through the dialyzer. This information is taken from the website https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.c. The facility staff failed to follow up on a fluid restriction recommendation from Resident #19's dialysis RD (registered dietician). Review of Resident #19's clinical record revealed a nutrition note dated 2/10/21, signed by the former facility RD that documented, The resident spoke with the Kitchen manager requesting a regular diet. She reports to staff and her renal dietitian that she consumes a regular diet at home. Per Renal RD, her labs [laboratory tests] are typically WNL (within normal limits) and they have no concerns with a diet change at this time .RD recommended fluid restriction but no specific value was obtained. Will discuss these changes with the resident and kitchen staff. Further review of Resident #19's clinical record failed to reveal the facility RD discussed a fluid restriction with Resident #19 or the dietary manager and failed to reveal the facility RD followed up with the renal RD regarding a fluid restriction. Resident #19's comprehensive care plan dated 2/11/21 documented, Renal insufficiencies related to: chronic renal failure with anemia. Coordinate dialysis care with dialysis treatment center . The care plan failed to document specific information regarding fluid restrictions. The former facility RD was no longer employed at the facility. On 4/21/21 at 2:41 p.m., an interview was conducted with OSM (other staff member) #5, the newly employed facility RD. OSM #5 was shown the above nutrition note and was asked what should have been done in regards to a fluid restriction for Resident #19. OSM #5 stated he would call the renal RD back to discuss specific details. OSM #5 stated he had not yet called the renal RD but he was planning on calling and making sure that he and the renal RD were on the right page. OSM #5 stated he does communicate with renal RDs and does talk about fluid restrictions because the renal RDs are the ones that follow the fluids that are taken out of residents at dialysis. On 4/22/21 at 9:43 a.m., an interview was conducted with Resident #19. Resident #19 stated she manages her own fluid restriction by drinking one cup of fluids with each meal then one additional cup each day. Resident #19 stated no facility staff had spoken with her regarding a fluid restriction. On 4/22/21 at 12:40 p.m., an interview was conducted with OSM #6 (the dietary manager). OSM #6 stated the former RD did not speak to him regarding a fluid restriction for Resident #19. On 4/21/21 at 6:08 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the quality consultant) were made aware of the above concern. The facility dialysis guidelines documented Both the center and the dialysis facility are responsible for shared communication regarding patients receiving dialysis services, either onsite or offsite . The facility fluid restrictions guideline documented, Fluid restrictions are sometimes used for patients with renal failure, congestive heart failure and hyponatremia (low sodium), or other condition requiring that intake of fluids be minimized. Specific total fluid restrictions are ordered by the physician and communicated to the dietary department. No further information was presented prior to exit. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32642 2. For Resident #67, the facility staff failed to obtain a physician's order for dialysis (1), failed to follow a physician's order for fluid restriction, failed to evidence documentation of assessment of her dialysis access site, and failed to maintain communication with the dialysis center. Resident #67 was admitted to the facility on [DATE], and most recently readmitted on [DATE], with diagnoses including ESRD (end stage renal disease) (2), diabetes (3), lymphedema (4), and bipolar disorder (5). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/12/21, Resident #67 was coded as having no cognitive impairment for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as receiving dialysis services. Resident #67 refused to be interviewed regarding dialysis. On the following dates and times: 4/20/21 at 11:38 a.m., 4/20/21 at 12:40 p.m., 4/20/21 at 1:45 p.m., 4/21/21 at 9:11 a.m., and 4/21/21 at 2:46 p.m., observations revealed Resident #67 was lying on her back in the bed. A review of Resident #67's clinical record revealed a readmission nursing assessment dated [DATE]. On this assessment, Resident #67 was documented as requiring hemodialysis, and documented as having a right upper chest catheter as the hemodialysis access site. Further review of Resident #67's clinical record revealed progress notes documenting Resident #67's leaving the facility and receiving hemodialysis on the following dates: 2/19/21, 3/3/21, 3/15/21, 3/17/21, 4/2/21, 4/5/21, 4/7/21, and 4/19/21. Further review of Resident #67's clinical record failed to reveal a physician's order for hemodialysis, for assessment of her access site for bruit and thrill (6), or for fluid restriction after her readmission on 2/17/21. A review of Resident #67's MARs (medication administration record) and TARs (treatment administration records) since 2/17/21 revealed no evidence of dialysis services, including site assessment or fluid restriction. A review of Resident #67 dialysis communication book revealed no evidence of any dialysis communication between the facility and dialysis center on 2/19/21, 3/3/21, 3/15/21, and 3/17/21. The dialysis communication book contained no communication from the dialysis center to the facility on [DATE] and 4/5/21. A review of Resident #67's comprehensive care plan, dated 11/8/2020 and updated 4/1/21, revealed, in part: Renal insufficiencies related to chronic renal failure .Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines .Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis and as needed . Coordinate dialysis care with dialysis treatment center .Dialysis 3X (three times) per week, T, TH, SA (Tuesday, Thursday, Saturday), fluid restriction 1500 mls (milliliters)/24 hours (in 24 hours). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/21 at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she takes care of Resident #67, she stated she does. When asked if Resident #67 receives dialysis, she stated the resident does sometimes. LPN #2 stated the resident is scheduled to go three times a week, but the resident is noncompliant, and frequently refuses to go to dialysis. When asked if Resident #67 should have an order for dialysis, LPN #2 stated the resident should have an order. She stated the resident should also have an order for assessment of her right upper chest port. When asked if Resident #67 is on a fluid restriction, LPN #2 stated, I thought so, but now I'm not so sure. She stated Resident #67 has problems with too much fluid and lymphedema, and she knows the resident was on a fluid restriction prior to being discharged from the facility and readmitted on [DATE]. LPN #2 stated the dialysis communication should always be filled out at the facility, then sent with the resident to dialysis. She stated the dialysis center should fill out their portion of the form, and return the communication book with the resident. LPN #2 stated this is important because, We want to know what they did to her. She stated if the dialysis book is returned to the facility with no information from the dialysis center, she would call the dialysis center and get a verbal report. On 4/21/21 at 6:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), and ASM #3, the quality consultant, were informed of these concerns. ASM #3 stated the communication form has two parts, and that the top of the form is filled out by facility staff. It includes the resident's vital signs, medications administered, and any other information the dialysis center might need to take care of a resident. The form is sent to the dialysis center with the resident. The bottom of the form should be filled out by dialysis center staff, including vital signs, weights, laboratory studies, or any other pertinent information regarding the resident's dialysis that day. The form is then returned to the facility. When asked how often this form should be utilized by both facility and dialysis center staff, ASM #3 stated it should be used every time the resident receives dialysis. When asked what the facility staff should do if the dialysis center has not filled out its portion of the form, ASM #3 stated the facility nurse should contact the dialysis center and get the information from the dialysis center staff. She stated this is important so the facility staff can know if any changes occurred in the resident's condition. On 4/22//21 at 1:41 p.m., LPN #5 was interviewed regarding the process staff follows for re-initiating orders for dialysis services when a resident is readmitted . LPN #5 stated, We go by what the doctor orders. When asked if she ever looks back to check a resident's orders before they were discharged to the hospital, she stated she does, sometimes. She stated if a resident should be on a fluid restriction, the fluid intake should be carefully tracked, and should be a coordinated effort between dietary staff and nursing. She stated the admitting nurse is responsible for making sure all orders are put into the electronic medical record (EMR). On 4/23/21 at 10:08 a.m., ASM #3 confirmed the orders for Resident #67's dialysis services, including receiving dialysis, fluid restriction, and assessment of access site were not a part of her current clinical record. ASM #3 stated, It just got missed. No further information was provided prior to exit. REFERENCES (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week. This information was taken from the website https://medlineplus.gov/dialysis.html. (2) End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD). This information is taken from the website https://medlineplus.gov/ency/article/000500.htm. (3) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (4) Lymphedema (LE) is the accumulation of protein-rich fluid in tissues. The impaired function of lymph vessels interrupts the drainage of lymphatic system that is a part of the circulatory system just like the arterial and venous structures. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5508242/#:~:text=Lymphedema%20(LE)%20is%20the%20accumulation,the%20arterial%20and%20venous%20structures. (5) Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks. This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (6) Your access is your lifeline. You will need to protect your access. Wash the area around your access with soap and warm water every day. Check the area for signs of infection, such as warmth or redness. When blood is flowing through your access and your access is working well, you can feel a vibration over the area. Let your dialysis center know if you can't feel the vibration. This information is taken from the website https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 31753 Based on staff interview and facility document review, it was determined that the facility staff failed to complete an annual CNA (certified nursing aide) performance review for one of five CNA record reviews. The facility staff failed to complete an annual performance review for CNA #5. The findings include: Review of CNA #5's record revealed the last performance review was completed for an appraisal period of March 2018 to March 2019. On 4/21/21 at 6:08 p.m., an interview was conducted with ASM (administrative staff member) #3 (the quality consultant). ASM #3 stated a list of CNAs who need a performance review is given to the director of nursing each month then the director of nursing either completes the performance reviews or has a unit manager or floor nurse complete the reviews. At this time, ASM #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 were made aware of the above concern. An email sent from ASM #1 on 4/22/21 at 8:27 a.m. documented, (CNA #5) performance evaluation: She was on a leave of absence 7/1/2020-9/1/2020 and again 2/15/2021-3/15/2021. She is on our list of evals (evaluations) to be completed due to the LOA (leave of absence) times. On 4/22/21 at 3:26 p.m., ASM #3 confirmed CNA #5's performance review could have been completed in between the times CNA #5 was not on a leave of absence. The facility policy titled, 1200.06 PERFORMANCE APPRAISALS documented, It is the policy of (name of company) that every employee's performance be reviewed and discussed with him/her by his/her immediate supervisor. 12. In the event of a promotion with an associated pay increase after the first anniversary date with the company, the employee's next merit increase will be 12 months from the effective date of his/her increase . No further information was presented prior to exit.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure one of 25 residents in the survey sample, (Resident #47), was free of a significant medication error. On the evening of 7/2/2020, Resident #47 was administered all of her multiple physician prescribed evening medications twice, by two nurses, LPN [licensed practical nurse] #4 and RN [registered nurse] #4, resulting in a significant medication error. Resident #47 was subsequently was transferred to a local hospital for evaluation/treatment. The hospital record documented Resident #47 was sleepy, weak and confused in the emergency room , displayed a drop in blood sugar, blood pressure and slow hear rate (bradycardia) readings; IV (intravenous) fluids, including dextrose were administered, the resident was then admitted to the hospital for monitoring due to the medications overdose. The findings include: Resident #47 was admitted to the facility on [DATE] and transferred to the hospital on 7/2/20. Resident #47's diagnoses included but were not limited to: bipolar disorder (1), seizures (2), diabetes mellitus (3) and atherosclerosis cardiac disease (4). Resident #47's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 3/15/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident as requiring limited assistance with mobility, transfers, dressing; supervision with personal hygiene and bathing and as independent in eating and locomotion. An annual assessment completed on 5/11/20 prior to the incident on 7/2/20 coded the resident as scoring a 9 out of 15 on the BIMS indicating Resident #47 was moderately impaired for cognition. Section N0350 Insulin: coded the resident as receiving insulin injections 7 out of 7 days of the look back period. The physician orders for Resident #47 in July 2020, documented in part the following: Medications scheduled administration time 5:00 PM: - Losartan (anti-hypertensive) (5) 100 milligram table by mouth in the afternoon for hypertension - Multivitamin (dietary supplement) 1 tablet by mouth in the afternoon for supplement, - Divalproax [Depakote] (anti-epileptic) (6) 625 milligram delayed response tablet twice a day for seizure prevention, - Metformin (anti-diabetic) (7) extended release tablet 500 milligram by mouth twice a day for diabetes mellitus, - Olopatadine (treats allergic conjunctivitis) (8) solution 0.1% instill 1 drop in both eyes twice a day for allergies, (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	- Humalog Mix 75/25- inject 50 units subcutaneously twice a day before breakfast and dinner, notify MD if blood sugar less than 60 or greater than 400. Hold Humalog 75/25 if blood sugar is less than 100. - Humalog (insulin) (9) 100 units/milliliter inject per sliding scale: if BS (blood sugar) 150-200 =4 units, BS 201-250=6 units, BS 251-300=8 units, BS 301-350=10 units, BS 351-400=12 units. If < 60 or > 350 or greater call physician, subcutaneously before meals for diabetes. Medications scheduled administration time 9:00 PM: - Atorvastin (anti-hyperlipidemic) (10) 10 milligram tablet by mouth at bedtime to lower cholesterol - Cetirizine (antihistamine) (11) 5 milligram tablet at bedtime for allergies - Gabapentin (anti-epileptic) (12) 600 milligram tablet at bedtime for nerve pain - Melatonin (treatment for insomnia) (13) milligram tablet by mouth at bedtime for sleep - Ziprasidone (antipsychotic) (14) 40 milligram capsule at bedtime for bipolar - Bisoprolol (antihypertensive) (15) 10 milligram twice a day for hypertension A FRI (facility reported incident) with an incident dated 7/2/20, and a reported date of 7/3/20, documented in part, Resident was given evening medication [all medications listed above] twice by two nurses. Resident's nurse practitioner requested the resident be sent to the hospital to be monitored due to the medication and her low blood pressure/pulse. Resident was admitted at the hospital for observation. Patient has no negative outcomes at this time. Employee action initiated or taken: Suspension/removed from schedule while investigation ongoing. Improvement plan and education initiated. If applicable date notification provided to: Responsible party: 7/3/2020, Physician: 7/3/2020, APS [adult protective services]: 7-3-2020, DHP [Department of Health Professions]: 7/3/2020 Review of the FRI investigation and follow up, documented in part, the following: Facility investigation: Completed on: the date 7/8/2020 was handwritten on the form. An included attachment documented in part the following: 7-8-2020 FRI day 5 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 7/2/2020 it was reported that a resident was given medication twice by two different nurses. During the investigation it was found that the resident was written on two different assignment sheets, [name of LPN #4] gave the medication first, without documenting the medication in the system. [Name of RN #2] gave the medication second. The MD [medical doctor] was notified and gave an order to send the resident to the ER [emergency room]. Resident [#47] was sent to the hospital and remained there two nights under observation status. Resident [#47] returned to the facility on [DATE] with no adverse reactions from the medication error and has remained stable. The DON [director of nursing] removed both nurses from the schedule while the investigation was ongoing, reconfigured the assignment sheets as well as educated the nursing staff on proper medication documentation. The investigation is complete. Another attachment titled, Trigger Call Guideline/Agenda documented in part the following: Event Type: Medication Error Date and Time of Event: 7/2/20@ [at] 9pm Patient Name: [Name of Resident #47] Cognitive Status/BIMS (date last completed): 9 as of 5/11/20 Timeline of Events: [Name of LPN #4] (Agency Nurse) administered the following medications to [name of Resident #47] at around 5:20pm: 4 units of Humalog insulin Humalog Mix 75/25- 50 units Metformin ER [extended release] 500 mg (milligram) MVI (multivitamin) Depakote 625 mg Losarten Potassium 100mg Bisoprolol Fumrate 10mg OlapTADINE HCL (hydrochloride) eye gtts (drops) [Name of LPN #5] administered the following medications around 8pm: Atrovastin Calcium10mg Gabapentin 600mg Melatonin 1mg (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ziprasidone HCL 40mg Around 9pm [Name of RN #2] asked [Name of LPN #4] to compare assignments to make sure that no one was missed. At that time they noticed that they both had [Name of Resident #47] on their assignment sheets and they both had given her [Resident #47] her scheduled medications. They both [RN #2 and LPN#4] both went immediately to assess the resident. The resident [Resident #47] was sleeping. She [Resident #47] was easily aroused and responsive to questions. Vital signs were taken at that time. BP 95/47, 57, 16, 96% on RA [blood pressure, pulse, respirations and oxygen saturation on room air]. [Name of nurse practitioner] was notified immediately and orders were received to sent [Sic] resident to ER [emergency room]. When EMT's [emergency medical technicians] arrived resident was able to answer questions and she walked to the stretcher. EMS [emergency medical services] took her [Resident #47] blood sugar which was 146. Resident was transported to [Name of hospital]. [Name of RN #2] called report to the ER Nurse to inform her of what medications the resident [Resident #47] received in duplicate. [Name of Resident #47's] Emergency Contact was notified of details of the incident this morning by [name of staff LPN]. DON called [Name of Resident #47's emergency contact] around 10am to explain the incident to her. During the investigation it was discovered that [Name of Resident #47] only received her Humalog 75/25 50 units once by [Name of LPN #4]. [* Note the sliding scale insulin was administered twice by both nurses for a total of 8 units of Humalog 100units/ ml]. Education has been initiated on Medication Administration to include signing off medications as you administer them to include giving medications timely as scheduled. The assignments sheets for the units were updated The final investigation included: Statements by RN (registered nurse) #2 and LPN (licensed practical nurse) #4, both involved in the medication error event. The MAR (medication administration record) for July 2020 for Resident #47 with initials sign on code of KO9 corresponding to RN #2. The Assignment sheets for RN #2 and LPN #4. A review of the clinical record failed to evidence any progress notes documenting the events of 7/2/20, regarding a medication error and/ or the residents transfer to the hospital. A review of vital signs on 7/2/20 at 6:23 AM, documented in part, Blood pressure 138/65, pulse 70. Resident #47's blood sugar at 4:30 PM was documented as 179. A review of a Discharge return anticipated MDS assessment with an assessment reference date of 7/2/20, documented in part, Unplanned transfer to acute hospital. A review of the hospital records for Resident #47, evidenced admission to an acute care hospital on 7/2/20-7/4/20. The emergency room record documented in part: EKG: Sinus bradycardia (slow heart rate (16)) rate of 51. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Emergency Department (ED) physician notes dated 7/2/20 11:28 PM, documented in part, She [Resident # 47] presents after getting a double dose of her medications which include extended release Metformin and Losartan. Her blood sugar dropped from 108 to 81. Her blood pressures have been on the soft side with maps (mean arterial pressures) around 65. She is getting a fluid bolus and I have ordered maintenance D5 (dextrose 5%) normal saline. Virginia Poison Control was contacted and suggests admission as Metformin was extended release and requires at least 12 hours of observation. She reports feeling sleepy, weak and somewhat confused. The ED (emergency room) RN [registered nurse) note dated 7/2/20 at 11:00 PM documented in part, RN spoke with 'RN#2' taking care of patient from the facility. States that patient received a double dose of her evening medication. 'RN#2' states patient was given medications around 6:00 PM and again at 9:00 PM. A review of the hospital discharge summary dated 7/4/20, documented in part, Admitting diagnosis and hospital course: Accidental overdose and hypoglycemia secondary to iatrogenic [Referring to a physical or mental condition caused by a physician or healthcare provider*] insulin. Discharge Diagnosis/Plan: Accidental overdose-patient now back to baseline. EKG (electrocardiogram) x two with normal QT intervals. Diabetes Type 2-resume sliding scale insulin. Initially insulin held on admission. Hypertension-blood pressure soft due to overdose. Received IV (intravenous) fluids in ED. BP stable at this time. LPN #4, an agency nurse, was not available for an interview and was not employed at the facility. An interview was conducted on 4/22/21 at 4:56 PM with RN #2, the nurse supervisor. RN #2 was the second nurse who administered medications to Resident #47 on 7/2/20. When asked if she remembered the medication error on 7/2/20, RN #2 stated, Oh yes, that was the error with the agency nurse who gave medicines and didn't chart, either time. I came to give the medications to the resident [Resident #47] on my assignment sheet and since they were not signed off, I gave the 6:00 PM and 9:00 PM medications. I did not know we were both assigned to the resident until about 9:00 PM. If I had seen the medications signed off, I would have asked the other nurse about the assignment and the medications. I checked on the resident and saw that she did not look well, so I called the nurse practitioner and we transferred her to the hospital. When asked if she remembered any changes or education that were made because of the medication error, RN #2 stated, Yes, they changed the assignment sheet and the number of medication carts. We also reviewed the medication administration policy. On 4/20/21 at 10:40 AM, during the entrance conference, when asked what standards of practice were followed, ASM (administrative staff member) #2, the director of nursing and ASM #3, the quality consultant stated, We use [NAME] and [NAME] & [NAME]. Administrative staff members (ASM) # 1, the administrator was made aware of the above concerns on 4/22/21 at 5:56 PM. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concerns on 4/23/21 at 10:08 AM. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	According to Basic Nursing, Essentials for Practice, 6th edition ([NAME] and [NAME], 2007, pages 349-360) A medication order is required for you to administer any medication to a patient. Once you receive and process a medication, place the physician's or health care provider's complete order on the appropriate medication form, the MAR. The MAR includes the patient's name, room, and bed number, as well as the names, dosages, frequencies, and routes of administration for each medication. When transcribing orders, ensure the names of medications, dosages, routes, and times are legible. The nurse checks all orders for accuracy and thoroughness. When orders are transcribed, the same information needs to be checked again by the nurse. It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the six rights of medication administration. 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation .Use the MAR to prepare and administer medications. When preparing medications in bottles or containers, compare the label of the medication container with the medication administration order three times: (1) before removing the container from the drawer or shelf, (2) as you remove the amount of medication ordered from the container, and (3) before returning the container to storage .After you administer medications, indicate which medications you gave on your patient's MAR per agency policy to show that you gave the medications as ordered. Inaccurate documentation of medications, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about your patient's care. There are many nursing actions you take to ensure the right documentation. Make sure that the information on your patient's MAR corresponds exactly with the prescriber's order and with the label on the medication's container. Record the administration of each medication as soon as you give the medication. Never document that you have given a medication until you have actually given it. A review of the facility assessment evidenced the facility Skills Competencies dated 10/2017, which documented in part, Medication management skills evaluation documents validation of medication management techniques and knowledge completed during job specific orientation and annually. The Medication Management Skills Evaluation CLS-228 (5/14), documented in part, Documents at time of administration on MAR/eMAR. Initiates incident report for medication administration errors. A review of the facility's Medication and Treatment Administration Guidelines dated 3/2018, documented in part, Medications and treatments administered are documented immediately following administration or per state specific standards. The facility enacted a plan of correction, which contained the following 5 points: 1. Nurse practitioner was immediately notified of medication administration error on 7/2/20 once discovered. LPN #4 and RN #2 administered medications at 5:00 PM and 9:00 PM. LPN #4 and RN #2 were both assigned to Resident #47. LPN #4 failed to document administration of medications at 5:00 PM and again at 9:00 PM. RN #2 administered 5:00 PM and 9:00 PM medications to Resident #47 as they had not been documented as given and she was unaware that LPN #4 was also assigned to Resident #47. 2. All Residents with medication administration of their prescribed medications including anti-hypertensive, diabetic, anti-hyperlipidemia, anti-epileptic, anti-psychotic and insulin have the potential to be affected by this deficient practice. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	3. All Nurses educated in person or via phone on 7/3/20 regarding the facility's Medication Administration policy dated 3/2018. LPN #4, an agency nurse, the nurse responsible for administration of the first dose of the 5:00 PM and the 9:00 PM medications was second check was terminated from the facility. 4. For the next month, an audit of medication administered and documented were reviewed by the director of nursing. The medication types reviewed included: anti-hypertensive, diabetic/insulin, anti-hyperlipidemia, anti-epileptic and anti-psychotic. All results and findings were presented and reviewed at the Quality meeting in August 2020. 5. Completion date 7/8/20. The credible evidence including the Plan of Correction, education, in-service sign in sheets, audits and Quality Council minutes were reviewed and found to be in order. Random interviews were conducted with staff on varying shifts regarding medication administration and documentation and failed to reveal any concerns. A medication pour/pass observation was completed during this survey. No further significant medication errors were identified. Review of current residents failed to identify any concerns. Past Noncompliance References: (1) Bipolar disorder is a mental disorder characterized by periods of mania and depression. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 71. (2) Seizures: a sudden, involuntary and violent contraction of a group of muscles, sometimes with loss of consciousness. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 137. (3) Diabetes mellitus: inability of insulin to function normally in the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 160. (4) Atherosclerosis cardiac disease: disorder of the cardiac arteries caused by a buildup of plaque which results in the vessels becoming non-elastic. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and [NAME], page 52. (5) Losartan potassium tablets are indicated for the treatment of hypertension in adults Overdosage: Limited data are available in regard to overdosage in humans. The most likely manifestation of overdosage would be hypotension and tachycardia; bradycardia could occur from parasympathetic (vagal) stimulation. If symptomatic hypotension should occur, supportive treatment should be instituted. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cda520b7-ae84-4bd7-b298-11934f4fcc57 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	(16) Bradycardia: bradycardia [brad?e-[NAME] de-ah] slowness of the heartbeat, so that the pulse rate is less than 60 per minute. This information was obtained from the website:https://medical-dictionary.thefreedictionary.com/bradycardia * This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/iatrogenic

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on clinical record reviews, facility document review and staff interviews it was determined that the facility failed to maintain a complete and accurate clinical record for eight of 25 residents in the current resident sample, Residents #44, #67, #25, #11, #80, #19, #24 and #47. The findings include: 1. The facility staff failed to maintain a complete and accurate clinical record documenting treatments completed for Resident #44. Resident #44 was admitted to the facility with diagnoses that included but were not limited to nontraumatic intracerebral hemorrhage (1) and tracheostomy (2). Resident #44's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of [DATE] coded Resident #44 as being non-verbal and severely impaired of making daily decisions. Section G coded Resident #44 as being totally dependent on two or more staff members for bed mobility, dressing and toileting and totally dependant on one staff member for eating and personal hygiene. Section M coded Resident #44 having one unstageable pressure ulcer (3). The current physician order summary for Resident #44 documented in part, - Body Audit- daily one time a day for skin observation. Order Date: [DATE]. - Sacral (4) wound- cleanse with normal saline, pack with anasep (wound cleanser) and 4x4's (gauze), skin prep (liquid film-forming dressing) peri wound (around the wound), cover with dry protective dressing, cover with transparent dressings. Change daily and prn (as needed) until resolved or no longer indicated. Order Date: [DATE]. - Cool air mist via trach collar (oxygen mask) continuous with O2 (oxygen) titrated in at 5 (five) liters every shift for respiratory failure (5). Order Date: [DATE]. - L (left) plantar (sole of foot)- cleanse with normal saline, apply skin prep daily until resolved or otherwise indicated for change. Order Date: [DATE]. - Suction every shift and as needed every shift for maintain patent (open) airway. Order Date: [DATE]. - Trach care daily and PRN: For disposable: remove and dispose inner cannula. Replace with new inner cannula. One time a day for reduce risk of infection. Order Date: [DATE]. The eTAR (electronic treatment administration record) dated [DATE]-[DATE] failed to evidence documentation for the following treatments on the following dates: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cool air mist via trach collar continuous with O2 titrated in at 5 liters every shift for respiratory failure. On [DATE] 3:15p, [DATE] 3:15p, [DATE] 3:15p, [DATE] 3:15p, [DATE] 11:15(p). - Suction every shift and as needed every shift for Maintain patent airway. On [DATE] 3:15p, [DATE] 3:15p, [DATE] 3:15p, [DATE] 3:15p, [DATE] 11:15(p). The eTAR (electronic treatment administration record) dated [DATE]-[DATE] failed to evidence documentation for the following treatments on the following dates: - Sacrum- cleanse with wound cleanser, apply Calmoseptine, cover with foam dressing and prn every day shift. On [DATE] 7:15a. - Trach care daily and PRN . On [DATE] 0900 (9:00 a.m.). - Cool air mist via trach collar continuous with O2 titrated in at 5 liters every shift for respiratory failure. On [DATE] 3:15p, [DATE] 7:15a, [DATE] 7:15a. - Suction every shift and as needed every shift for Maintain patent airway. On [DATE] 11:15(p), [DATE] 3:15p, [DATE] 7:15a. The eTAR (electronic treatment administration record) dated [DATE]-[DATE] failed to evidence documentation for the following treatments on the following dates: - Santyl ointment 250 unit/gm (unit per gram) (collagenase) Apply to sacrum topically every day shift for wound care. On [DATE] 0900 (9:00 a.m.), [DATE] 7:15a, [DATE] 7:15a. - Trach care daily and PRN . On [DATE] 0900 (9:00 a.m.), [DATE] 0900, [DATE] 0900. - Cool air mist via trach collar continuous with O2 titrated in at 5 liters every shift for respiratory failure. On [DATE] 7:15a, [DATE] 3:15p, 11:15(p), [DATE] 7:15a, [DATE] 7:15a. - Suction every shift and as needed every shift for Maintain patent airway. On [DATE] 7:15a, [DATE] 3:15p, [DATE] 7:15a, [DATE] 7:15a, [DATE] 11:15(p), [DATE] 3:15p. The eTAR (electronic treatment administration record) dated [DATE]-[DATE] failed to evidence documentation for the following treatments on the following dates: - Body Audit- daily one time a day for skin observation. On [DATE] 0900 (9:00 a.m.), [DATE] 0900, [DATE] 0900, [DATE] 0900, [DATE] 0900. - L (left) plantar- cleanse with normal saline, apply skin prep daily until resolved or otherwise indicated for change . On [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a. - Sacral wound- cleanse with normal saline, apply Santyl, pack with 4x4's, skin prep peri wound, cover with dry protective dressing, cover with transparent dressings. Change daily and prn until resolved or no longer indicated . On [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Santyl ointment 250 unit/gm (collagenase) Apply to sacrum topically every day shift for wound care. On [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a. - Trach care daily and PRN . On [DATE] 0900 (9:00 a.m.), [DATE] 0900, [DATE] 0900, [DATE] 0900, [DATE] 0900, [DATE] 0900. - Cool air mist via trach collar continuous with O2 titrated in at 5 liters every shift for respiratory failure. On [DATE] 7:15a, [DATE] 3:15p, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 11:15(p), [DATE] 7:15a, [DATE] 7:15a, [DATE] 3:15p. - Suction every shift and as needed every shift for Maintain patent airway. On [DATE] 7:15a, [DATE] 3:15p, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 7:15a, [DATE] 3:15p. The eTAR (electronic treatment administration record) dated [DATE]-[DATE] failed to evidence documentation for the following treatments on the following dates: - Body Audit- daily one time a day for skin observation. On [DATE] 0900 (9:00 a.m.). - Anasept Antimicrobial Gel 0.057% Apply to sacral wound topically every day shift for wound . On [DATE] 7:15a, [DATE] 7:15a. - L plantar- cleanse with normal saline, apply skin prep daily until resolved or otherwise indicated for change . On [DATE] 7:15a. - Sacral wound- cleanse with normal saline, pack with anasep and 4x4's, skin prep peri wound, cover with dry protective dressing, cover with transparent dressings. Change daily and prn until resolved or no longer indicated . On [DATE] 7:15a, [DATE] 7:15a. - Trach care daily and PRN . On [DATE] 0900 (9:00 a.m.). - Cool air mist via trach collar continuous with O2 titrated in at 5 liters every shift for respiratory failure. On [DATE] 11:15(p), [DATE] 11:15(p), [DATE] 7:15a, 11:15(p). - Suction every shift and as needed every shift for Maintain patent airway. On [DATE] 11:15(p), [DATE] 11:15(p), [DATE] 7:15a, 11:15(p). On [DATE] at approximately 11:55 a.m., an interview was conducted with ASM (administrative staff member) #3. ASM #3 stated that the nurses signed off on the eTAR that wound care was completed and they documented by exception. ASM #3 stated that refusals of care were documented each occurrence. ASM #3 stated that the empty spaces on the eTARS would be a deficient practice but they could not say that the treatments were not done and that it was a failure to document. On [DATE] at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that treatments were documented on the eTAR. LPN #8 stated that the documentation was evidence that the treatment was completed on that date and time. LPN #8 stated that if the eTAR was blank the treatment was not done. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 11:20 a.m., a request was made to ASM #1, ASM #2, ASM #3 and ASM #4 for additional documentation regarding Resident #44's pressure ulcer and for documentation of body audits completed, wound care, tracheostomy care, oxygen administration and suctioning completed from [DATE] through the present on the dates listed above. ASM #1, the administrator requested to have staff sign a written declaration that the treatments listed above were completed but not documented. ASM #1 was advised to have the responsible staff interview with surveyors regarding the dates that treatments were not documented. On [DATE] at approximately 2:08 p.m., an interview was conducted with LPN #5. LPN #5 stated that when they had a wound nurse they provided treatment to the wound and when they were not there the nurse assigned to the resident provided the treatment. LPN #5 stated that treatments were documented on the eTAR and if the eTAR was blank the treatment was not done. On [DATE] at approximately 5:00 p.m., a second interview was conducted with LPN #8. LPN #8 stated that the computers at the facility glitched frequently and they had provided the treatments to Resident #44's sacral wound each day Monday through Friday. On [DATE] at approximately 9:17 a.m., an interview was conducted with LPN #1. LPN #1 stated that they provided treatments to Resident #44 on the days they were assigned to them and had forgotten to sign them off on the eTAR. LPN #1 stated that they also have computer glitches and treatments that they sign off on the eTAR do not always show as signed off. LPN #1 stated that they have problems with all of their laptops not saving the documentation on the eTARs. On [DATE] at approximately 9:12 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated that they provided treatments to Resident #44 on the days they were assigned to them and had forgotten to document them. RN #4 stated that they also have problems with the internet in the building and the laptops do not save their documentation on the eTARS at times. On [DATE] at approximately 9:17 a.m., an interview was conducted with LPN #7. LPN #7 stated that they had provided treatments to Resident #44 on the days they were assigned to them and had forgotten to document them. The facility policy Medication and Treatment Administration Guidelines dated ,d+[DATE] .Updated ,d+[DATE] documented in part, .Documentation: Medications and treatments administered are documented immediately following administration or per state specific standards . The facility policy Focus on F Tag 842, undated, documented in part, .The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions . On [DATE] at approximately 10:05 a.m., ASM (administrative staff member) #1, ASM #2, the director of nursing and ASM #3, the quality consultant were made aware of the findings. No further information was provided prior to exit. Reference: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Intracerebral hemorrhage: Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm. 2. Tracheostomy: A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. 3. Pressure ulcer are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000147.htm. 4. Sacral: The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis. Joined at the very end of the sacrum are two to four tiny, partially fused vertebrae known as the coccyx or tail bone. The coccyx provides slight support for the pelvic organs but actually is a bone of little use. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm 5. Respiratory failure: When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 32642 2. For Resident # 67, the facility staff failed to document treatment administered for pressure injuries during March, April, and May of 2021. Resident #67 was admitted to the facility on [DATE], and most recently readmitted on [DATE], with diagnoses including ESRD (end stage renal disease) (2), diabetes (3), lymphedema (4), and bipolar disorder (5). The most recent MDS (minimum data set) assessment, an annual assessment with an ARD (assessment reference date) of [DATE], coded Resident #67 as coded as having no cognitive impairment for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as having one stage 2 pressure injury, which was present on admission or re-entry. Resident #67 refused to be interviewed regarding her pressure injuries. On the following dates and times: [DATE] at 11:38 a.m., [DATE] at 12:40 p.m., [DATE] at 1:45 p.m., [DATE] at 9:11 a.m., and [DATE] at 2:46 p.m., Resident #67 was observed lying on her back in the bed. During all observations, Resident #67 was observed to be lying on a pressure-relieving mattress. On [DATE] at 2:46, p.m., Resident #67's wound care was observed. RN #1 showed both feet and Resident #67's sacrum. No wounds were visible at this time. A review of Resident #67's Braden Scale Assessment for risk of developing pressure injuries dated [DATE] revealed that she was at high risk, having scored 12. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #67's clinical record revealed the following orders, and the following dates for which the TAR (treatment administration record) contained no evidence that the treatments were administered according to the orders: - [DATE]: Sacral wound- Cleanse with NS. Apply calcium alginate and foam dsg. daily. Every day shift for wound care. Not documented as administered [DATE], [DATE]. - [DATE]: Sacral wound- Cleanse with NS. Apply Silvasorb to calcium alginate, apply to wound bed, cover with dry protective dressing. Change daily and prn (as needed) until resolved. Every day shift for skin alteration. Not documented as administered [DATE]. - [DATE]: R heel - apply skin prep daily every day shift for skin alteration. Not documented as done [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 11:53 a.m., ASM (administrative staff member) #3, the quality consultant, ASM #1, the administrator, RN (registered nurse) #1, and ASM #2, the DON (director of nursing) were interviewed. When asked about the multiple instances of lack of documentation that treatments were completed for pressure injuries, she stated it would definitely be a deficient practice. She stated it would be a failure to document. She stated: We can't evidence it was done if it's not documented. She stated the DON and unit managers review the TARs, and are responsible for overseeing that treatments are getting done. On [DATE] at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she took care of Resident #25, she stated she did. When shown the TARs for Resident #67 from February, March and April of 2021 and asked about the lack of evidence that pressure injury treatments were done, LPN #2 stated If there is a hole or a blank, it was note done. A medication or a treatment. On [DATE] at 11:31 a.m., ASM #3, ASM #1, and ASM #2 were informed of the multiple instances in Resident #67's TARs where pressure injury treatments were not documented as done. On ,d+[DATE]//21 at 1:41 p.m., LPN #5 was interviewed. She stated after she completes a pressure injury treatment, she signs it on the TAR. When asked what can be said about a treatment if there is blank on the TAR where a nurse signature should be, she stated: It was not done. On [DATE] at 4:18 p.m., LPN #2 returned to request another interview with the survey team. She stated she had been thinking about something she had said during the previous day's conversation, and wanted to clarify. She stated if there is a hole in the MAR or TAR, the treatment could have been done. She stated the staff may have gotten pulled away for an urgent event like a resident's fall. LPN #2 stated, If it's not signed, it may have been done. LPN #2 stated: Some things, I can tell you I did. Some things, I might not be able to tell you. When shown the blanks in the TARs for pressure injury treatments for Resident #67, she stated, some of the days in March, I was here, but the wound nurse was here, too. She stated it would be hard to determine which was which. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 5:05 p.m., LPN #2 and LPN #8 requested to meet again with the survey team. LPN #8 stated she functions as the wound nurse when she is in the building, but she cannot stage wounds because she is not an RN. She stated if there were holds in the TARs for a resident for pressure injury care on a Saturday or a Sunday, she does not do wound care on the weekends. LPN #8 stated if there was a day that she did work as the wound nurse, but did not sign the TAR, it was just an oversight. She also stated the facility computers frequently have glitches during which they do not save information that has been signed by the nurses on TARs. On [DATE] at 8:41 a.m., LPN #1 was interviewed. She stated she was absolutely certain that any holes in the TARs on shifts she worked were documentation errors. She stated the facility computers have glitches that will not allow nurses to save information they have signed on resident records. On [DATE] at 9:12 a.m., RN #4 was interviewed. She stated she was certain that any treatments scheduled for residents on days she worked had been done, regardless of whether the treatments were documented as done on the TAR. On [DATE] at 9:17 a.m., LPN #7 was interviewed. She stated that holes in the TAR could mean that she just forgot to sign off on a resident's treatment. She stated the computers do not always record what a nurse initially enters. No further information was provided prior to exit. REFERENCES (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. (2) End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD). This information is taken from the website https://medlineplus.gov/ency/article/000500.htm. (3) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (4) Lymphedema (LE) is the accumulation of protein-rich fluid in tissues. The impaired function of lymph vessels interrupts the drainage of lymphatic system that is a part of the circulatory system just like the arterial and venous structures. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5508242/#:~:text=Lymphedema%20(LE)%20is%20the%20accumulation,the%20arterial%20and%20venous%20structures. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(5) Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks. This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (6) Alginate dressings are absorbent wound care products that contain sodium and calcium fibers derived from seaweed. They come in the form of flat dressings that can be placed over open ulcers and rope dressings that are used for packing the wound, which absorb fluids and promote healing with pressure ulcers, diabetic foot ulcers, or venous ulcers. An individual dressing is able to absorb up to 20 times its own weight. These dressings, which are easy to use, mold themselves to the shape of the wound, which helps ensure that they absorb wound drainage properly. This also makes these dressings ideal for using on ulcers in areas that are difficult to dress, such as heels and sacral areas. This information is taken from the website https://advancedtissue.com/,d+[DATE]/treating-wounds-with-absorbent-alginate-dressings/. (7) SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal. This information is taken from the manufacturer's website https://www.santyl.com/. (8) The Pressure Ulcer Scale for Healing (PUSH Tool) was developed by the National Pressure Ulcer Advisory Panel (NPUAP) as a quick, reliable tool to monitor the change in pressure ulcer status over time . The NPUAP recommends use of the PUSH Tool at regular intervals. The AHCPR Treatment Guideline recommends assessments be performed at least weekly and if the condition of the patient or of the wound deteriorates. The PRESSURE ULCER HEALING CHART (which is attached to the PUSH Tool) will allow you to graph PUSH Tool scores over time for each ulcer. You should be able to tell at a glance whether the ulcer is healing, remains unchanged, or is deteriorating. The PUSH Tool is designed to monitor the three critical parameters that are the most indicative of healing. In developing specific treatment plans, you will need to assess additional parameters (e.g., foul odor, color of exudate, undermining, and tunneling). Any increase in the PUSH Tool score (indicating wound deterioration) requires a more complete assessment of the ulcer and the patient's overall condition. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/push_tool_information_form.pdf. 3. For Resident #25, the facility staff failed to document treatment administered for pressure injuries during March, April, and May of 2021. Resident #25 was admitted to the facility on [DATE] with diagnoses including epilepsy, COPD (chronic obstructive pulmonary disease) (2), and diabetes (3). The most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of [DATE], coded Resident #25 as moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). He was coded as being totally dependent on the assistance of staff members for all activities of daily living. He was coded as having one pressure injury at a stage 1 (4), and one pressure injury at a stage 2 (5). Both pressure injuries were coded as present on admission. Resident #25 declined to be interviewed during the survey. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the following dates and times: [DATE] at 11:40 a.m., [DATE] at 12:47 p.m., [DATE] at 1:48 p.m., and [DATE] at 9:11 a.m., Resident #25 was observed lying on his back in bed. During each observation, he was observed wearing pressure-relieving boots on both feet, and resting on a pressure-relieving mattress. A review of Resident #21's Braden Scale Assessment for risk of developing pressure injuries dated [DATE] revealed that he was at high risk, having scored 11. Review of Resident #25's clinical record revealed the following orders, and the following dates for which the TAR (treatment administration record) contained no evidence that the treatments were administered according to the orders: - [DATE]: L heel - cleanse with normal saline, apply skin prep to peri wound, apply puracol plus (6), cover with dry protective dressing. Change daily and prn until resolved. Every day shift for skin alteration. Not documented as administered [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. - [DATE]: R lateral foot near 5th digit - cleanse with normal saline, apply skin prep, cover with dry protective dressing. Change every Tues, Thurs, Sat and prn until resolved. Every day shift every Tue, Thu, Sat. Not documented as administered [DATE], [DATE], [DATE], [DATE], and [DATE]. - [DATE]: R lateral foot - cleanse with normal saline, apply skin prep, cover with dry protective dressing. change tues (Tuesday), thurs (Thursday), sat (Saturday), and prn until resolved. Every day shift every Tue, Thu, Sat for skin alteration. Not documented as administered [DATE] and [DATE]. - [DATE]: R lateral foot - cleanse with normal saline, apply skin prep, daily and prn until resolved. Every day shift for skin alteration. Not documented as administered [DATE], [DATE], and [DATE]. - [DATE]: Santyl (7) Ointment 250 UNIT/GM (units per gram) (Collagenase). Apply to R lat (lateral) foot (by 5th toe) topically every day shift for wound. See wound care order. Not documented as administered [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 11:53 a.m., ASM (administrative staff member) #3, the quality consultant, ASM #1, the administrator, RN (registered nurse) #1, and ASM #2, the DON (director of nursing) were interviewed. When asked about the multiple instances of lack of documentation that treatments were completed for pressure injuries, she stated it would definitely be a deficient practice. She stated it would be a failure to document. She stated: We can't evidence it was done if it's not documented. She stated the DON and unit managers review the TARs, and are responsible for overseeing that treatments are getting done. On [DATE] at 2:57 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if she took care of Resident #25, she stated she did. When shown the TARs for Resident #25 from February, March and April of 2021 and asked about the lack of evidence that pressure injury treatments were done, she stated If there is a hole or a blank, it was note done. A medication or a treatment. On [DATE] at 11:31 a.m., ASM #3, ASM #1, and ASM #2 were informed of the multiple instances in Resident #25's TARs where pressure injury treatments were not documented as done. (continued on next page)

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	495283	A. Building B. Wing	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On ,d+[DATE]//21 at 1:41 p.m., LPN #5 was interviewed. She stated after she completes a pressure injury treatment, she signs it on the TAR. When asked what can be said about a treatment if there is blank on the TAR where a nurse signature should be, she stated: It was not done. On [DATE] at 4:18 p.m., LPN #2 returned to request another interview with the survey team. She stated she had been thinking about something she had said during the previous day's conversation, and wanted to clarify. She stated if there is a hole in the MAR or TAR, the treatment could have been done. She stated the staff may have gotten pulled away for an urgent event like a resident's fall. LPN #2 stated, If it's not signed, it may have been done. LPN #2 stated: Some things, I can tell you I did. Some things, I might not be able to tell you. When shown the blanks in the TARs for pressure injury treatments for Resident #67, she stated, some of the days in March, I was here, but the wound nurse was here, too. She stated it would be hard to determine which was which. On [DATE] at 5:05 p.m., LPN #2 and LPN #8 requested to meet again with the survey team. LPN #8 stated she functions as the wound nurse when she is in the building, but she cannot stage wounds because she is not an RN. She stated if there were holds in the TARs for a resident for pressure injury care on a Saturday or a Sunday, she does not do wound care on the weekends. LPN #8 stated if there was a day that she did work as the wound nurse, but did not sign the TAR, it was just an oversight. She also stated the facility computers frequently have glitches during which they do not save information that has been signed by the nurses on TARs. On [DATE] at 8:41 a.m., LPN #1 was interviewed. She stated she was absolutely certain that any holes in the TARs on shifts she worked were documentation errors. She stated the facility computers have glitches that will not allow nurses to save information they have signed on resident records. On [DATE] at 9:12 a.m., RN #4 was interviewed. She stated she was certain that any treatments scheduled for residents on days she worked had been done, regardless of whether the treatments were documented as done on the TAR. On [DATE] at 9:17 a.m., LPN #7 was interviewed. She stated that holes in the TAR could mean that she just forgot to sign off on a resident's treatment. She stated the computers do not always record what a nurse initially enters. No further information was provided prior to exit. REFERENCES (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. (2) COPD is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and [NAME], page 124. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3) Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high. This information is taken from the website https://medlineplus.gov/diabetes.html. (4) Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. (5) Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertrigi [TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29125 Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to administer medication in a sanitary manner to prevent the spread of infection for one of 5 residents in the Medication Administration task, (Resident #28). During the medication observation RN #4 used her bare finger to tap at a Cardizem pill that was not easily dislodged from the packaging, her bare finger was in direct contact with the Cardizem pill that was partially protruding from the package. RN #4 dislodged the Cardizem pill from the package into the pill cup. RN #4 then administered The findings include: The facility staff failed to administer a medication, Cardizem (1), in a sanitary manner for Resident #28. Resident #28 was admitted to the facility on [DATE] with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, dementia, high blood pressure, schizophrenia, atrial fibrillation and diabetes. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/24/21. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, supervision for all other areas of activities of daily living except for eating, which was coded as being independent. A review of the clinical record revealed an order dated 9/12/19 for Cardizem CD Capsule Extended Release 24 Hour 360 MG (milligrams) Give 1 capsule by mouth one time a day for htn (high blood pressure) On 4/21/21 at 8:30 AM, RN #4 (Registered Nurse) was observed preparing and administering medications for Resident #28. She was observed sanitizing her hands prior to starting preparation of the medications for Resident #28. As she went through the process of preparing the medications for Resident #28, RN #4 was observed touching the drawers of the medication cart, the computer, the packages of medications, the medication cup and other supplies on top of her medication cart, thus re-contaminating her hands. The Cardizem was the 5th medication she prepared for Resident #28, having touched the medication cart, drawers, and packages from other medications first. Observation revealed the Cardizem capsule was not easily removed from the package and RN #4 used her bare finger to tap at the pill, her bare finger was in direct contact with the Cardizem pill that was partially protruding from the package. RN #4 dislodged the Cardizem pill from the package into the pill cup. RN #4 then administered the medications, including the Cardizem that she had touched, to the Resident #28. On 4/21/21 09:26 AM in an interview with RN #4 she stated that you should not touch pills with your hands. RN #4 stated that she did not realize she had done that. A review of the facility policy Medication and Treatment Administration Guidelines documented, Medications are administered in accordance with standards of practice (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to [NAME] and Perry's, Fundamentals of Nursing, 6th edition, page 847, For safe administration, the nurse uses aseptic technique when handling and giving medications. Skill 1: Administering Oral Medications: 6. Prepare the required medications: b. Multidose containers: When removing tablets or capsules . pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. Do not touch tablets or capsules with hands. Rationale: Pouring capsules or tablets into your hand is unsanitary. 12. Transport medications to patient bedside carefully . 14. Perform hand hygiene and put on PPE [personal protective equipment] if indicated. Rationale: Hand hygiene and PPE prevent the spread of microorganisms. PPE is required based on transmission based precautions. 20. Administer the medications. [NAME] Photo Atlas of Medication Administration, Sixth Edition, [NAME] B [NAME], EdD, MSN RN, Wolters Kluwe, 2019, pages 2, 3, 4 and 6. On 4/21/21 at 6:00 PM at the end of day meeting, ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided by the end of the survey. (1) Cardizem - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a684027.html