STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to notify the physician of missed medication for one of 15 sampled residents, Resident #212. The findings included: Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of Resident #212's medical record revealed that Resident #212 had an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for pain relief. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c (wheelchair), appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 x10 days. Review of Resident #212's July 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Start Date: 7/13/21 2100 (9 p.m.). Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p. m. dose of [MEDICATION(S)] on 7/13/21. Review of Resident #212's July MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Evidence could not be shown that the nurses obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m. Review of the Omnicell list of STAT medications revealed that [MEDICATION(S)] 50 mg was a medication available in the Omnicell. On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview. On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if [MEDICATION(S)] 50 mg was in the Omnicell, LPN #2 stated, Yes, I know that is in the STAT box. When asked if that is where she pulled Resident's #212's [MEDICATION(S)] on 7/14/21, LPN #2 stated, Yes, I pulled from the STAT box. On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive her ordered [MEDICATION(S)] on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled [MEDICATION(S)] on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, Yes. When asked if this included scheduled pain medications, RN #2 stated, Yes. When asked why Resident #212 did not receive her scheduled [MEDICATION(S)] on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, She didn't have [MEDICATION(S)]. When asked what she had meant by that statement, RN #2 stated, She didn't have a narcotic card at all. RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have [MEDICATION(S)] on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if [MEDICATION(S)] was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the [MEDICATION(S)] because the resident was being sent home with a script for [MEDICATION(S)] anyway.When asked if it was acceptable for residents to not receive their ordered medications, RN #2 stated that it wasn't. On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened to Resident #212's [MEDICATION(S)] on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's [MEDICATION(S)], LPN #1 stated that she did not. When asked if she attempted to pull the [MEDICATION(S)] from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the [MEDICATION(S)] from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of [MEDICATION(S)]. On 8/4/21 at 4:40 p.m., an interview was conducted with ASM (Administrative Staff Member) #4, the Nurse Practitioner. She could not recall being made aware that Resident #211 had missed all her doses of scheduled ordered [MEDICATION(S)]. ASM #4 stated that the physician may have been aware. ASM #4 stated that she expected the nursing staff to make her aware in order for her to give further direction. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, Yes. When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's [MEDICATION(S)], ASM #2 stated that she didn't see where the [MEDICATION(S)] was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the [MEDICATION(S)] has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. On 8/5/21 at 11:19 a.m., an interview was conducted with ASM #5, the physician. He could not recall being made aware that Resident #211 had missed all her scheduled doses of [MEDICATION(S)]. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, Facility policy titled, Medication Shortage/Unavailable Medications documents in part, the following: Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified . 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. COMPLAINT DEFICIENCY

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on representative interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice by signing off medications were administered to two of 15 residents; Residents #212 and #211 that were not available. The findings included: 1. Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days. Review of Resident #212's July 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Start Date: 7/13/21 2100 (9 p.m.). Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p. m. dose of [MEDICATION(S)] on 7/13/21. Review of Resident #212's July 2021 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Evidence could not be shown that the nurses obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Omnicell list of medications revealed that [MEDICATION(S)] 50 mg was a medication available in the Omnicell. On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if [MEDICATION(S)] 50 mg was in the Omnicell, LPN #2 stated, Yes, I know that is in the STAT box. When asked if that is where she pulled Resident's #212's [MEDICATION(S)] on 7/14/21, LPN #2 stated, Yes, I pulled from the STAT box. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of [MEDICATION(S)] on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, I don't remember why I signed that off. When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, No ma'am. When asked what why the [MEDICATION(S)] had not made it to the facility, LPN #2 stated, I don't know exactly the cause. On 8/5/21 during a pre-exit meeting, ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility could not provide a policy or professional standard for the above concerns. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. 2. Resident #211 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated [DATE]. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's [MEDICATION(S)] (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to her stomach and feeling itchy all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed [MEDICATION(S)]. Resident #211's care plan dated 6/24/21 documented the following for pain: Resident is at risk for pain related to [CONDITION(S)] (Stroke) with right [CONDITION(S)] .Administer analgesics/medications per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] Review of Resident #211's June, July and August 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . This order was initiated on 6/24/21. Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that [MEDICATION(S)] was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m. Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of [MEDICATION(S)]. The first dose of [MEDICATION(S)] was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her [MEDICATION(S)] on 7/4/21 at 9:00 p.m.; where it was documented she had (zero) capsules left. Review of the second narcotic sheet for [MEDICATION(S)] revealed that pharmacy had delivered 30 capsules of [MEDICATION(S)] on 7/9/21. Resident #211's first dose of [MEDICATION(S)] was on 7/9/21 at 2100 (9:00 p.m.). There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13 administrations). Review of the facility STAT Omnicell list revealed that [MEDICATION(S)] 100 mg was in the Omnicell STAT box. Further review of Resident #211's July 2021 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 2 p.m. and 9 p.m. 7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m. 7/8/21 at 6:00 a.m. and 9:00 p.m. and 7/9/21 at 6:00 a.m. The following administration note was documented on 7/5/21 at 7:51 p.m.: On hold until received per NP (Nurse Practitioner). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following note was documented on 7/6/21 by the Nurse Practitioner: .Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting) .Neuropathy: Continue [MEDICATION(S)] ([MEDICATION(S)]) 100 mg TID, script renewed. On 7/7/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg- Give 1 mg by mouth three times a day for pain .pharmacy to send. On 7/8/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg .needs hard script. MD (medical doctor) aware. On 7/9/21 at 10:29 a.m., the following administration note was documented: [MEDICATION(S)] 100 mg three times a day for pain .per MD, administrator, DON (Director of Nursing) ok to give now. Further review of Resident #211's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 6:00 a.m., 7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m., 7/8/21 at 2:00 p.m. On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it was determined that the pharmacy did not receive a script for the [MEDICATION(S)] until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve [MEDICATION(S)] for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull [MEDICATION(S)] from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the [MEDICATION(S)] on the above dates. OSM #2 stated that the pharmacy initially sent out 28 capsules of [MEDICATION(S)] on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out [MEDICATION(S)] was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received [MEDICATION(S)] in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a. m. OSM #2 stated that the request to retrieve the [MEDICATION(S)] was made from the DON (Director of Nursing). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 5:00 p.m., an interview was conducted with the DON (Director of Nursing) (ASM (Administrative Staff Member) #2. When asked if there was has been issues obtaining scripts for narcotics or getting those scripts to the pharmacy; ASM #2 stated, Yes. When asked what had happened with Resident #211's [MEDICATION(S)] as the NP had documented that she wrote a script on 7/6/21; ASM #2 stated that she was unaware that Resident #211's [MEDICATION(S)] prescription had run out until the son had come into the building on 7/9/21. ASM #2 stated that he was upset that his mom had missed her [MEDICATION(S)] for several days and wanted to know what was going on with it. ASM #2 stated that she had called the medical doctor to obtain a script that day. ASM #2 stated that she pulled the medication out of the Omnicell and the nurse administered the medication, but could not remember the time. ASM #2 stated that she realized the resident had been out sometime before she initiated getting the resident her [MEDICATION(S)]. When asked if the son really had initiated obtaining his mom's medication, ASM #2 stated, Yes, it was in response to the son coming in. ASM #2 stated that she expected her nurses to follow up with [MEDICATION(S)] and not wait days later before obtaining the medication. ASM #2 stated that she was not sure what they did do, didn't do for the [MEDICATION(S)]. When asked if Resident #211 had an increase amount of pain related to missing 12 doses of [MEDICATION(S)], ASM #2 stated that she didn't think so, that this information was never reported to her. When asked if nursing staff should be documenting that medications are being administered when they are not in fact given, ASM #2 stated, Absolutely not. When asked if nursing staff should have pulled [MEDICATION(S)] from the Omnicell and administered the medication, ASM #2 stated that nursing staff could do that if there was a script for the medication. ASM #2 stated that she expected her staff to inquiring on why the gapabentin was not available and if it needed a script to call the physician, obtain a script and fax that to the pharmacy. ASM #2 stated that once the pharmacy has a script, the medication can be pulled from the Omnicell. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building with access. ASM #2 stated that she was not aware that not all nurses had access and didn't realize this was the responsibility of the DON to ensure their access. ASM #2 confirmed that all nurses should have access to the Omnicell if they are responsible for passing out medications, and that she was going to work on getting all nurses access. The nurses who had documented that they had administered the [MEDICATION(S)], when it was in fact, not administered could not be reached for an interview. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. (1) [MEDICATION(S)] is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/ 471/. COMPLAINT DEFICIENCY

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to administer four doses of Scheduled IV narcotic pain medication, [MEDICATION(S)] per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The findings included: Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of Resident #212's medical record revealed that Resident #212 had an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Electronic Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of a therapy note dated 7/13/21 revealed that Resident #212 was having increased pain on 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercises), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o (complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days. Review of Resident #212's July 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Start Date: 7/13/21 2100 (9 p.m.). Further review of Resident #212's July 2021 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212 did not receive her 9 p.m. dose of [MEDICATION(S)] on 7/13/21. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #212's July MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Evidence could not be shown that the nurses obtained the ordered [MEDICATION(S)] from the Omnicell (narcotic STAT box). Review of Resident #212's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m. Review of the Omnicell list of medications revealed that [MEDICATION(S)] 50 mg was a medication available in the Omnicell. On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview. On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if [MEDICATION(S)] 50 mg was in the Omnicell, LPN #2 stated, Yes, I know that is in the STAT box. When asked if that is where she pulled Resident's #212's [MEDICATION(S)] on 7/14/21, LPN #2 stated, Yes, I pulled from the STAT box. On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive her ordered [MEDICATION(S)] on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that. On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled [MEDICATION(S)] on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, Yes. When asked if this included scheduled pain medications, RN #2 stated, Yes. When asked why Resident #212 did not receive her scheduled [MEDICATION(S)] on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, She didn't have [MEDICATION(S)]. When asked what she had meant by that statement, RN #2 stated, She didn't have a narcotic card at all. RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have [MEDICATION(S)] on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if [MEDICATION(S)] was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the [MEDICATION(S)] because the resident was being sent home with a script for [MEDICATION(S)] anyway.When asked if it was acceptable for residents to not receive their ordered medications, RN #2 stated that it wasn't. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened to Resident #212's [MEDICATION(S)] on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's [MEDICATION(S)], LPN #1 stated that she did not. When asked if she attempted to pull the [MEDICATION(S)] from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the [MEDICATION(S)] from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of [MEDICATION(S)]. On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, Yes. When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's [MEDICATION(S)], ASM #2 stated that she didn't see where the [MEDICATION(S)] was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the [MEDICATION(S)] has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of [MEDICATION(S)] on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, I don't remember why I signed that off. When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, No ma'am. When asked what why the [MEDICATION(S)] had not made it to the facility, LPN #2 stated, I don't know exactly the cause. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, Medication Shortage/Unavailable Medications documents in part, the following: Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified . 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In Fundamentals of Nursing 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. COMPLAINT DEFICIENCY

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to ensure [MEDICATION(S)] measures were provided to one of 15 residents in the survey sample, Resident #212 who requested pain medication on 7/13/21 and 7/14/21. The findings included: Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of Resident #212's medical record revealed that Resident #212 had an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident #212's July TAR (Treatment Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for [MEDICATION(S)]. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. There was no evidence on Resident #212's MAR (Medication Administration Record) that nursing administered prn (as needed) Tylenol to Resident #212 on 7/13/21. There was no evidence of any non-pharmacological [MEDICATION(S)] measures provided to Resident #212 on 7/13/21. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o (complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days. Further review of Resident #212's MAR revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p.m. dose of [MEDICATION(S)] on 7/13/21. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a therapy note dated 7/14/21 documented in part, the following: .reported increased R knee pain . Pt left sitting up in wc (wheelchair) and NRSG (nursing) arriving to administer pain meds .Pt reported 7/10 p in R knee, NRSG made aware that pt requested pain meds. Review of Resident #212's MAR revealed that there was no evidence that nursing administered administered prn (as needed) Tylenol to Resident #212 on 7/14/21. There was no evidence of any non-pharmacological [MEDICATION(S)] measures provided to Resident #212 on 7/14/21. Further review of the July MAR revealed that a nurse had signed off that she had administered the scheduled [MEDICATION(S)] at 9:00 a.m. Evidence (Narcotic sheets) could not be provided to show that the ordered [MEDICATION(S)] had made it to the facility from pharmacy. Evidence could not be shown that the nurse obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's pain care plan dated 7/2/21 documented the following: The resident has pain r/t (related to) Right knee pain AEB closed fracture of right tibial plateau, Osteroarthritis .Administer analgesics per orders, Anticipate the patient's need for [MEDICATION(S)] and respond to any complaint of pain as needed. Assess/document for probable cause of each pain episode. Remove/limit causes where possible . On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. On 8/5/21 at 10:41 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on both 7/13/21 and 7/14/21. When asked if she recalled therapy speaking to her about Resident #212's increased pain on both 7/13/21 and 7/14/21; LPN #2 stated that she didn't recall specific days but that they usually let her know. When asked if she provided any [MEDICATION(S)] measures to Resident #212 on 7/13/21 and 7/14/21 after therapy had alerted her of Resident #212's pain; LPN #2 stated, I don't remember. When asked if medications are usually signed off on the MAR after they are administered, LPN #2 stated that medications are to be signed off after they have been administered. This writer showed LPN #2 Resident #212's MAR and the lack of evidence that PRN medication was administered. LPN #2 stated, I must not have given it then. When asked how she signed off that she had administered a 9 a.m. dose of [MEDICATION(S)] on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, I don't remember why I signed that off. When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, No ma'am. When asked if non-pharmacological interventions rendered for pain should be documented, LPN #2 stated that it should. LPN #2 stated again that she wasn't sure what happened, that sometimes therapy makes the pain sound bigger than it is and maybe she asked the resident and the resident was fine. LPN #2 could not provide evidence of a pain assessment conducted for Resident #212 on 7/13/21 and 7/14/21. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/21 at 11:19 a.m., an interview was conducted with OSM #4, the PTA (Physical Therapy Assistant) who worked with Resident #212 on both 7/13/21 and 7/14/21. OSM #4 stated that the first day she had worked with the resident, the resident had declined her therapy due to pain. OSM #4 stated that the second day, Resident #212 was still having pain to that right knee but was able to participate some in therapy. OSM #4 stated that she had alerted the nurse on duty both times regarding her pain. OSM #4 stated that she could not specify who she had told. When asked if she had actually seen the nurse administer pain medication or provide non-pharmacolgical relief interventions; to Resident #212, OSM #4 stated that she did not witness that. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility could not provide a policy or professional standard for the above concerns. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. COMPLAINT DEFICIENCY

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on representative interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure medications were procured for two of 15 residents in the survey sample; Resident #212 and #211. The findings included: 1. Resident #212 was admitted to the facility on [DATE] with diagnoses that included but were not limited to chronic heart failure, closed fracture of the right tibia with healing, pain in right knee, and high blood pressure. Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of Resident #212's medical record revealed that Resident #212 had an order for the following prn pain medication: Tylenol Tablet 325 mg (milligram) Give 3 tablets by mouth every 6 hours as needed for pain. Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for pain relief. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days. Review of Resident #212's July 2021 POS (Physician Order Summary) revealed the following order: [MEDICATION(S)] HCl Tablet 50 MG Give 1 tablet by mouth two times a day for Pain for 10 Days. Start Date: 7/13/21 2100 (9 p.m.). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p. m. dose of [MEDICATION(S)] on 7/13/21. Review of Resident #212's July MAR revealed that nurses were signing off that they had administered the scheduled [MEDICATION(S)] on 7/14/21 at 9:00 a.m. and 9:00 p.m. Evidence (Narcotic sheets) could not be provided to show that the ordered [MEDICATION(S)] had made it to the facility from pharmacy. Evidence could not be shown that the nurses obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's MAR also revealed that she missed her 9 a.m. dose of [MEDICATION(S)] on 7/15/21 (hours before her discharge home on 7/15/21). Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m. Review of the Omnicell list of medications revealed that [MEDICATION(S)] 50 mg was a medication available in the Omnicell. On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview. On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if [MEDICATION(S)] 50 mg was in the Omnicell, LPN #2 stated, Yes, I know that is in the STAT box. When asked if that is where she pulled Resident's #212's [MEDICATION(S)] on 7/14/21, LPN #2 stated, Yes, I pulled from the STAT box. On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive her ordered [MEDICATION(S)] on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled [MEDICATION(S)] on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, Yes. When asked if this included scheduled pain medications, RN #2 stated, Yes. When asked why Resident #212 did not receive her scheduled [MEDICATION(S)] on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, She didn't have [MEDICATION(S)]. When asked what she had meant by that statement, RN #2 stated, She didn't have a narcotic card at all. RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have [MEDICATION(S)] on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if [MEDICATION(S)] was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the [MEDICATION(S)] because the resident was being sent home with a script for [MEDICATION(S)] anyway.When asked if it was acceptable for residents to not receive their ordered medications, RN #2 stated that it wasn't. On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened to Resident #212's [MEDICATION(S)] on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's [MEDICATION(S)], LPN #1 stated that she did not. When asked if she attempted to pull the [MEDICATION(S)] from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the [MEDICATION(S)] from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of [MEDICATION(S)]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, Yes. When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's [MEDICATION(S)], ASM #2 stated that she didn't see where the [MEDICATION(S)] was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the [MEDICATION(S)] has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for the scheduled [MEDICATION(S)] or a script (Prescription). OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of [MEDICATION(S)] on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, I don't remember why I signed that off. When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, No ma'am. When asked what why the [MEDICATION(S)] had not made it to the facility, LPN #2 stated, I don't know exactly the cause. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, Medication Shortage/Unavailable Medications documents in part, the following: Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified . 2. If a medication shortage is discovered during normal pharmacy hours: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. 2. Resident #211 was admitted to the facility on [DATE] with diagnoses that included but were not limited to cerebral infarction (stroke), right sided [CONDITION(S)] (paralysis) following stroke, type two diabetes mellitus, and [CONDITION(S)] requiring [CONDITION(S)]. Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated [DATE]. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's [MEDICATION(S)] (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to her stomach and feeling itchy all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed [MEDICATION(S)]. Resident #211's care plan dated 6/24/21 documented the following for pain: Resident is at risk for pain related to [CONDITION(S)] (Stroke) with right [CONDITION(S)] .Administer analgesics/medications per physician's orders . Review of Resident #211's June, July and August 2021 POS (Physician Order Summary) revealed the following order: [MEDICATION(S)] 100 mg (milligrams) 100 mg capsule by mouth Three Times Daily. This order was initiated on 6/24/21. Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that [MEDICATION(S)] was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m. Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of [MEDICATION(S)]. The first dose of [MEDICATION(S)] was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her [MEDICATION(S)] on 7/4/21 at 9:00 p.m; where it was documented she had (zero) capsules left. Review of the second narcotic sheet for [MEDICATION(S)] revealed that pharmacy had delivered 30 capsules of [MEDICATION(S)] on 7/9/21. Resident #211's first dose of [MEDICATION(S)] was on 7/9/21 at 2100 (9:00 p.m.). There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13 administrations). Review of the facility STAT Omnicell list revealed that [MEDICATION(S)] 100 mg was in the Omnicell STAT box. Further review of Resident #211's July 2021 MAR revealed that staff had not administered the [MEDICATION(S)] on the following dates: 7/5/21 at 2 p.m. and 9 p.m. 7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m. 7/8/21 at 6:00 a.m. and 9:00 p.m. and 7/9/21 at 6:00 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following administration note was documented on 7/5/21 at 7:51 p.m.: On hold until received per NP (Nurse Practitioner). The following note was documented on 7/6/21 by the Nurse Practitioner: .Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting) .Neuropathy: Continue [MEDICATION(S)] ([MEDICATION(S)]) 100 mg TID, script renewed. On 7/7/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg- Give 1 mg by mouth three times a day for pain .pharmacy to send. On 7/8/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg .needs hard script. MD (medical doctor) aware. On 7/9/21 at 10:29 a.m., the following administration note was documented: [MEDICATION(S)] 100 mg three times a day for pain .per MD, administrator, DON (Director of Nursing) ok to give now. Further review of Resident #211's MAR revealed that [MEDICATION(S)] was documented as administered on the following dates; however there was no evidence that facility staff had pulled [MEDICATION(S)] from the facility STAT box: 7/5/21 at 6:00 a.m., 7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m., 7/8/21 at 2:00 p.m. On 8/4/21 at 2:45 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6, the nurse who worked the 11-7 shifts with Resident #211 and who did not administer her scheduled [MEDICATION(S)] at 6:00 a.m. When asked the process if she were to administer a narcotic and it was not available on the medication cart, LPN #6 stated that she would check to see if the medication was already ordered. LPN #6 stated that if the medication says its on order she would wait for the next shift to follow up as she is night shift. When asked what happened with Resident #211's [MEDICATION(S)], LPN #6 stated that she remembered the medication not being up from pharmacy for a couple of days. When asked what was going on with the [MEDICATION(S)], LPN #6 stated, No Idea. LPN #6 denied following up personally with the gapabentin to see why it had been missing for several days. LPN #6 denied Resident #211 having an increase in pain. She could not recall the resident complaining of nausea or an itchy feeling. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it was determined that the pharmacy did not receive a script for the [MEDICATION(S)] until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve [MEDICATION(S)] for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull [MEDICATION(S)] from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the [MEDICATION(S)] on the above dates. OSM #2 stated that the pharmacy initially sent out 28 capsules of [MEDICATION(S)] on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out [MEDICATION(S)] was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received [MEDICATION(S)] in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a.m. OSM #2 stated that the request to retrieve the [MEDICATION(S)] was made from the DON (Director of Nursing). When asked if there was any side effects or withdrawal effects to missing 12 doses of [MEDICATION(S)], OSM #2 stated that there was not necessarily any withdrawal effects, that missing that many doses would lead to pain returning back. OSM #2 stated that he would expect pain to return by the second missed dose. When asked if missing 12 administrations was considered a significant error, OSM #2 stated that he wouldn't say significant but that the resident would be uncomfortable. When asked if missing 12 doses could make someone who uses it for pain feel nauseous or itchy all over; OSM #2 stated that he could imagine it would make someone feel anxious which could lead to an upset stomach. OSM #2 was not familiar with [MEDICATION(S)] withdrawals causing an itchy feeling unless it was the really the pins and needles feeling. Further review of Resident #211's clinical record revealed no evidence of an increase in pain or a decrease in appetite during the time of her missed doses of [MEDICATION(S)]. The following; however was documented in a physical therapy note dated 7/8/21: Pt found supine in bed c/o (complaints) of not receiving her meds the last 3 days and says she is having withdrawal symptoms as she is itchy all over. PT attempts to consult nurse regarding this issue with PT unable to locate nurse. The next therapy note dated 7/9/21, documented in part, the following: Pt (Patient) found supine in bed, empathetic discussion had as pt reports she has not had her meds on the last 4 days. Nurse consulted regarding issue. Pt reports feeling itchy all over and nauseous. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/21 at 5:00 p.m., an interview was conducted with the DON (Director of Nursing) (ASM (Administrative Staff Member) #2. When asked if there was has been issues obtaining scripts for narcotics or getting those scripts to the pharmacy; ASM #2 stated, Yes. When asked what had happened with Resident #211's [MEDICATION(S)] as the NP had documented that she wrote a script on 7/6/21; ASM #2 stated that she was unaware that Resident #211's [MEDICATION(S)] prescription had run out until the son had come into the building on 7/9/21. ASM #2 stated that he was upset that his mom had missed her [MEDICATION(S)] for several days and wanted to know what was going on with it. ASM #2 stated that she had called the medical doctor to obtain a script that day. ASM #2 stated that she pulled the medication out of the Omnicell and the nurse administered the medication, but could not remember the time. ASM #2 stated that she realized the resident had been out sometime before she initiated getting the resident her [MEDICATION(S)]. When asked if the son really had initiated obtaining his mom's medication, ASM #2 stated, Yes, it was in response to the son coming in. ASM #2 stated that she expected her nurses to follow up with [MEDICATION(S)] and not wait days later before obtaining the medication. ASM #2 stated that she was not sure what they did do, didn't do for the [MEDICATION(S)]. When asked if Resident #211 had an increase amount of pain related to missing 12 doses of [MEDICATION(S)], ASM #2 stated that she didn't think so, that this information was never reported to her. When asked if nursing staff should be documenting that medications are being administered when they are not in fact given, ASM #2 stated, Absolutely not. When asked if nursing staff should have pulled [MEDICATION(S)] from the Omnicell and administered the medication, ASM #2 stated that nursing staff could do that if there was a script for the medication. ASM #2 stated that she expected her staff to inquiring on why the gapabentin was not available and if it needed a script to call the physician, obtain a script and fax that to the pharmacy. ASM #2 stated that once the pharmacy has a script, the medication can be pulled from the Omnicell. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building with access. ASM #2 stated that she was not aware that not all nurses had access and didn't realize this was the responsibility of the DON to ensure their access. ASM #2 confirmed that all nurses should have access to the Omnicell if they are responsible for passing out medications, and that she was going to work on getting all nurses access. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. (1) [MEDICATION(S)] is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/ 471/. COMPLAINT DEFICIENCY

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Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on representative interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that facility staff failed to ensure one of 15 residents, Resident #211 was free from a significant medication error. The findings included: Resident #211 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated [DATE]. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21. On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's [MEDICATION(S)] (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to her stomach and feeling itchy all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed [MEDICATION(S)]. Resident #211's care plan dated 6/24/21 documented the following for pain: Resident is at risk for pain related to [CONDITION(S)] (Stroke) with right [CONDITION(S)] .Administer analgesics/medications per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] Review of Resident #211's June, July and August 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . This order was initiated on 6/24/21. Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that [MEDICATION(S)] was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m. Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of [MEDICATION(S)]. The first dose of [MEDICATION(S)] was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her [MEDICATION(S)] on 7/4/21 at 9:00 p.m.; where it was documented she had (zero) capsules left. Review of the second narcotic sheet for [MEDICATION(S)] revealed that pharmacy had delivered 30 capsules of [MEDICATION(S)] on 7/9/21. Resident #211's first dose of [MEDICATION(S)] was on 7/9/21 at 2100 (9:00 p.m.). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13 administrations). Review of the facility STAT Omnicell list revealed that [MEDICATION(S)] 100 mg was in the Omnicell STAT box. Further review of Resident #211's July 2021 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 2 p.m. and 9 p.m. 7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m. 7/8/21 at 6:00 a.m. and 9:00 p.m. and 7/9/21 at 6:00 a.m. The following administration note was documented on 7/5/21 at 7:51 p.m.: On hold until received per NP (Nurse Practitioner). The following note was documented on 7/6/21 by the Nurse Practitioner: .Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting) .[CONDITION(S)]: Continue [MEDICATION(S)] ([MEDICATION(S)]) 100 mg TID, script renewed. On 7/7/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg- Give 1 mg by mouth three times a day for pain .pharmacy to send. On 7/8/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg .needs hard script. MD (medical doctor) aware. On 7/9/21 at 10:29 a.m., the following administration note was documented: [MEDICATION(S)] 100 mg three times a day for pain .per MD, administrator, DON (Director of Nursing) ok to give now. Further review of Resident #211's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 6:00 a.m., 7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m., 7/8/21 at 2:00 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 2:45 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6, the nurse who worked the 11-7 shifts with Resident #211 and who did not administer her scheduled [MEDICATION(S)] at 6:00 a.m. When asked the process if she were to administer a narcotic and it was not available on the medication cart, LPN #6 stated that she would check to see if the medication was already ordered. LPN #6 stated that if the medication says its on order she would wait for the next shift to follow up as she is night shift. When asked what happened with Resident #211's [MEDICATION(S)], LPN #6 stated that she remembered the medication not being up from pharmacy for a couple of days. When asked what was going on with the [MEDICATION(S)], LPN #6 stated, No Idea. LPN #6 denied following up personally with the gapabentin to see why it had been missing for several days. LPN #6 denied Resident #211 having an increase in pain. She could not recall the resident complaining of nausea or an itchy feeling. On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it was determined that the pharmacy did not receive a script for the [MEDICATION(S)] until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve [MEDICATION(S)] for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull [MEDICATION(S)] from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the [MEDICATION(S)] on the above dates. OSM #2 stated that the pharmacy initially sent out 28 capsules of [MEDICATION(S)] on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out [MEDICATION(S)] was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received [MEDICATION(S)] in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a. m. OSM #2 stated that the request to retrieve the [MEDICATION(S)] was made from the DON (Director of Nursing). When asked if there was any side effects or withdrawal effects to missing 12 doses of [MEDICATION(S)], OSM #2 stated that there was not necessarily any withdrawal effects, that missing that many doses would lead to pain returning back. OSM #2 stated that he would expect pain to return by the second missed dose. When asked if missing 12 administrations was considered a significant error, OSM #2 stated that he wouldn't say significant but that the resident would be uncomfortable. When asked if missing 12 doses could make someone who uses it for pain feel nauseous or itchy all over; OSM #2 stated that he could imagine it would make someone feel anxious which could lead to an upset stomach. OSM #2 was not familiar with [MEDICATION(S)] withdrawals causing an itchy feeling unless it was the really the pins and needles feeling. Further review of Resident #211's clinical record revealed no evidence of an increase in pain or a decrease in appetite during the time of her missed doses of [MEDICATION(S)]. The following; however was documented in a physical therapy note dated 7/8/21: Pt found supine in bed c/o (complaints) of not receiving her meds the last 3 days and says she is having withdrawal symptoms as she is itchy all over. PT attempts to consult nurse regarding this issue with PT unable to locate nurse. The next therapy note dated 7/9/21, documented in part, the following: Pt (Patient) found supine in bed, empathetic discussion had as pt reports she has not had her meds on the last 4 days. Nurse consulted regarding issue. Pt reports feeling itchy all over and nauseous. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 5:00 p.m., an interview was conducted with the DON (Director of Nursing) (ASM (Administrative Staff Member) #2. When asked if there was has been issues obtaining scripts for narcotics or getting those scripts to the pharmacy; ASM #2 stated, Yes. When asked what had happened with Resident #211's [MEDICATION(S)] as the NP had documented that she wrote a script on 7/6/21; ASM #2 stated that she was unaware that Resident #211's [MEDICATION(S)] prescription had run out until the son had come into the building on 7/9/21. ASM #2 stated that he was upset that his mom had missed her [MEDICATION(S)] for several days and wanted to know what was going on with it. ASM #2 stated that she had called the medical doctor to obtain a script that day. ASM #2 stated that she pulled the medication out of the Omnicell and the nurse administered the medication, but could not remember the time. ASM #2 stated that she realized the resident had been out sometime before she initiated getting the resident her [MEDICATION(S)]. When asked if the son really had initiated obtaining his mom's medication, ASM #2 stated, Yes, it was in response to the son coming in. ASM #2 stated that she expected her nurses to follow up with [MEDICATION(S)] and not wait days later before obtaining the medication. ASM #2 stated that she was not sure what they did do, didn't do for the [MEDICATION(S)]. When asked if Resident #211 had an increase amount of pain related to missing 12 doses of [MEDICATION(S)], ASM #2 stated that she didn't think so, that this information was never reported to her. When asked if nursing staff should be documenting that medications are being administered when they are not in fact given, ASM #2 stated, Absolutely not. When asked if nursing staff should have pulled [MEDICATION(S)] from the Omnicell and administered the medication, ASM #2 stated that nursing staff could do that if there was a script for the medication. ASM #2 stated that she expected her staff to inquiring on why the gapabentin was not available and if it needed a script to call the physician, obtain a script and fax that to the pharmacy. ASM #2 stated that once the pharmacy has a script, the medication can be pulled from the Omnicell. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building with access. ASM #2 stated that she was not aware that not all nurses had access and didn't realize this was the responsibility of the DON to ensure their access. ASM #2 confirmed that all nurses should have access to the Omnicell if they are responsible for passing out medications, and that she was going to work on getting all nurses access. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, Medication Shortage/Unavailable Medications documents in part, the following: Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified . 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. Review of the Omniview Drug Information documents in part, the following: [MEDICATION(S)] is used with other medications to prevent and control seizures. It is also used to relieve nerve pain following shingles . This drug may also be used for restless leg syndrome or other nerve pain conditions (such as diabetic [CONDITION(S)], peripheral [CONDITION(S)], [CONDITION(S)] .Do not stop taking this medication without consulting your doctor. Some conditions may become worse when the drug is suddenly stopped. Your dose may need to be gradually decreased .If you miss a dose, take it as soon as you remember. COMPLAINT DEFICIENCY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, and staff interviews the facility's staff failed to afford the opportunity to get out of bed daily as desired for 1 of 36 residents (Resident #50), in the survey sample. The findings included: Resident #50 was originally admitted to the facility 12/3/14 and readmitted [DATE] after an acute care hospital stay. The current diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. In section G (Physical functioning) the resident was coded as requiring total care of two people with transfers, total care of one person with bed mobility, personal hygiene, bathing, transfers, dressing, and toileting, and supervision after set-up with eating. An interview was conducted with Resident #50 on 3/16/21 at approximately 12:40 p.m. Resident #50 stated the walls were closing in on him because he had been under observation for 14 days after discharge from the hospital and since his transfer to the general population unit there continued to be days in which staff wouldn't get him up. Resident #50 stated he required two people to get him out of bed using a mechanical lift and the staff states they don't have enough staff to get him up but his roommate requires the exact same assistance yet he is out of bed daily and early. On 3/17/21 at approximately 11: 00 a.m., and again at approximately 1:00 p.m., the resident was in bed due to a scheduled appointment which required him to be in bed until it was completed. After staff learned the appointment was canceled at approximately 1:30 p.m., the resident wasn't transferred to get out of bed until late afternoon. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 3/18/21 at approximately 12:55 p. m. CNA #1 stated the facility had eliminated itself of problematic CNAs and hired others but; they continued to struggle with CNA staffing because of frequent call outs, especially Thursday through Sunday. CNA #1 further stated Resident #50 was left in bed on days in which staffing was a problem. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/21 the Resident #50 was again left in bed though, he constantly rung his call bell for someone to get him out bed. At approximately 2:20 p.m., Certified Nursing Assistant (CNA) #3 informed Resident #50, they were very busy and if there was time after rounds were completed for a specific assignment they would get him out of bed into his wheel chair but the plan was contingent on the length of time necessary to complete the other assignment. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated the resident should be out of bed as desired based on his preference and every effort would be made to accommodate the resident going forward.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, clinical record review, staff interview and review of facility documentation, the facility staff failed to ensure dignity was maintained for 3 residents (#409, #50, and #35). The facility staff failed to protect Resident #409 from body exposure to public view and provide his personal clothing. Resident #50 and #35 were not provided dignity covers for bedside drainage bags. The findings included: 1. Resident #409 was originally admitted to the nursing facility on 1/30/21 with diagnoses that included [CONDITION(S)], [CONDITION(S)], cervical disc degeneration, and readmitted on [DATE] with an added diagnoses of TIAs (mini strokes), acute [MEDICATION(S)] and kidney failure. The Admission Minimum Data Set (MDS) assessment dated [DATE] coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 3 out of a possible score of 15 which indicated the resident was severely impaired in the necessary cognitive skills for daily decision making. Resident #409 required extensive assistance from one staff for bed mobility, transfers, ambulation in and out of his room, personal hygiene and bathing. The resident was totally dependent on one staff for dressing and toilet use. The resident was assessed not steady without staff assistance for moving from a seated to a standing position, walking, turning around and face the opposite direction while walking, moving on and off the toilet and surface to surface transfer. Resident #409 was coded continent of bowel and bladder. The resident was assessed to have fallen in the last month, last 2-6 months and since admission without fractures. The care plan dated 2/1/21 identified that Resident #409 had a self-care deficit. The goal set by the staff for the resident was that his needs would be met. Some of the approaches the staff would implement to accomplish this goal included assist with activities of daily living, dressing, grooming, toileting and oral care. The following observations were made of Resident #409: On 3/16/21 at 11:15 a.m., the resident was sitting in his wheelchair with overbed table across from the nurse's station dressed in a hospital gown and non-skid socks on both feet. The resident could make request for basic needs, but was unable to carry on connection of thoughts during a prolonged conversation. On 3/16/21 at 12:25 p.m., the resident remained dressed as previously observed and eating his lunchmeal. He stated his lunch was, Pretty good. On 3/16/21 at 1:00 p.m., the resident was walking around in his room without a hospital gown in just his brief and non-skid socks. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/16/21 at 1:25 p.m., the resident continued to walk around in his room without clothing as previously observed. The resident was holding onto foot of the bed to the end table, reaching out to this surveyor. Two staff persons were summoned to the room by this surveyor to assist the resident. Certified Nursing Assistant (CNA) #3 and Licensed Practical Nurse (LPN) #6 came to the resident's room and when asked if he had clothing, they stated that the resident had no family and no clothing. LPN #6 said the resident wore hospital gowns because he had no clothing. There was no clothes in any of the resident's drawers or hanging in his wardrobe, but there was a package of thick gray socks on his bedside table. LPN #6 put the resident's hospital gown back on and sat him in his wheelchair. CNA #3 said that the resident should have been at the nurse's station because he would try to stand up and possibly fall. The resident kept pointing to a package of thick gray socks and said They would feel good. The LPN stated to the resident that he needed to wear the non-skid socks so he would not slip on the floor. When asked where his clothes were, he stated he did not know. On 3/16/21 at 2:30 p.m., Resident #409 was sitting in his wheelchair at the nurse's station on Unit I fully clothed with shirt, pants and regular thick gray socks. The resident stated he was warmer today. The overbed table was in front of the resident and he was thumbing through magazines. LPN #6 stated the staff obtained the clothes from the lost and found. On 3/17/21 at 9:30 a.m., Resident #409 was fully clothed and also had on a zip up hoodie, sitting in his wheelchair at the nurse's station, finishing his breakfast meal. The Patient Care Assistant (PCA) stated there was clothes in the lost and found for any resident without clothing and that several volunteer churches often donate clothing. On 3/18/21 at 11:47 a.m., an interview was conducted with the Unit Manager (UM) LPN #1 and the Social Worker (SW). They stated that the nursing staff did not approach either of them about the resident not having clothing. The UM stated she expected the staff to have let her know and she would have called the resident's legal guardian. She stated the resident came with a cane, but no clothes and wore hospital gowns, but the staff got clothing the last couple of days from the laundry lost and found. The SW said reiterated that if the lack of clothing was an issue she knew about she would have called the resident's legally appointed guardian to ask for clothing and shoes. On 3/18/21 at 1:34 p.m., An interview was conducted with the Admission's Coordinator who was asked if she knew whether or not the resident was admitted with personal belongings. She who stated she remembered seeing Resident #409 wearing clothing when he was on Unit II. The resident did not have a record of his personal belongings. On 3/18/21 at 4:14 p.m., a debriefing was held with the Administrator, Director of Nursing (DON) and Regional Vice President of Operations (RVPO). The DON stated she was going to research why the resident did not have any clothing. They voiced no one approached them about having to only put hospital gowns on the resident because he had no clothing. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/21 at 6:11 p.m., the DON and the Admission's Coordinator said the resident had been transferred to the hospital from Unit II on 2/9/21 and returned on 2/11/21, spent time in quarantine and then transferred to Unit I on 2/25/21. The Admission's Coordinator said the CNA who packed up the resident's belongings was interviewed on the phone and stated she placed them in the soiled utility room on Unit II. They said, We have now found his clothes in the soiled utility room. They were never transferred on 2/26/21 to his current room on Unit I. If a resident is gone 3 days, they are discharged and clothes are then placed in the soiled utility room based on the policy guidance for room changes during the Pandemic. There was no explanation as to why there was no attempt to locate the resident's clothing prior to 3/18/21 and or ensure clothing was obtained prior to 3/16/21 which resulted in his needless exposure to public view, and had the potential to negatively impact his dignity. The facility's policy and procedure titled Resident Rights undated indicated that all residents had the right to dignity, respect and freedom, and to be treated with consideration, respect, dignity and security of possessions. 2. The facility's staff failed to maintain Resident #50's dignity by ensuring the bedside drainage bag fluid was concealed from view. Resident #50 was originally admitted to the facility 12/3/14 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; [CONDITION(S)] and [CONDITION(S)] bladder. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. In section H (Bladder and Bowel) the resident was coded as requiring use of an indwelling catheter. On 3/17/21 at approximately 11:00 a.m., and again at 1:00 p.m., Resident #50 was observed in bed. Viewable from the hallway was a bedside drainage bag with approximately 600 milliliters (ml) of light yellow urine inside. On 3/18/21 at approximately 12:20 p.m., Resident #50 was again observed in bed. Viewable from the hallway was a bedside drainage bag with approximately 900 milliliters (ml) of light yellow urine inside. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 3/18/21 at approximately 12:55 p. m. CNA #1 stated the resident had a dignity cover for his bedside drainage bag because she put it on three days ago when the resident was up in the wheel chair. CNA #1 located the dignity cover in a chair in Resident #50's room, she put the cover on the bedside drainage bag and left the room. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated a bedside drainage bags should have a dignity covers on it. 3. The facility's staff failed to maintain Resident #35's dignity by ensuring the bedside drainage bag fluid was concealed from view. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #35 was originally admitted to the facility 2/16/21 and the resident hadn't been discharged since this admission. The current diagnoses included; [CONDITION(S)]. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/22/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #35's cognitive abilities for daily decision making were intact. In section H (Bladder and Bowel) the resident was coded as requiring use of an indwelling catheter. On 3/16/21 at approximately 1:45 p.m., Resident #35 was observed in bed with a bedside drainage bag viewable upon entering the room. The drainage bag contained yellow urine. On 3/18/21 at approximately 11:05 a.m., Resident #35 was again observed in bed. Viewable from the hallway was a bedside drainage bag holding yellow urine. On 3/18/21 at approximately 12:10 p.m., Resident #35 was observed in bed. Viewable from the hallway was a bedside drainage bag containing yellow urine. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 3/18/21 at approximately 12:55 p. m. CNA #1 stated the resident had a dignity cover for his bedside drainage bag because she put it on. CNA #1 stated she would put the cover on Resident #35's bedside drainage bag. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated a bedside drainage bags should have a dignity covers on it. The facility's policy titled Indwelling Urinary Catheter Care Procedure with a revision date of 11/3/20, read under Procedure #11; Ensure drainage bag is covered with a privacy/dignity cover.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to notify the physician of missed medication for one of 15 sampled residents, Resident #212. The findings included: Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of Resident #212's medical record revealed that Resident #212 had an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for pain relief. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c (wheelchair), appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 x10 days. Review of Resident #212's July 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Start Date: 7/13/21 2100 (9 p.m.). Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p. m. dose of [MEDICATION(S)] on 7/13/21. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #212's July MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Evidence could not be shown that the nurses obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m. Review of the Omnicell list of STAT medications revealed that [MEDICATION(S)] 50 mg was a medication available in the Omnicell. On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview. On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if [MEDICATION(S)] 50 mg was in the Omnicell, LPN #2 stated, Yes, I know that is in the STAT box. When asked if that is where she pulled Resident's #212's [MEDICATION(S)] on 7/14/21, LPN #2 stated, Yes, I pulled from the STAT box. On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive her ordered [MEDICATION(S)] on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that. On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled [MEDICATION(S)] on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, Yes. When asked if this included scheduled pain medications, RN #2 stated, Yes. When asked why Resident #212 did not receive her scheduled [MEDICATION(S)] on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, She didn't have [MEDICATION(S)]. When asked what she had meant by that statement, RN #2 stated, She didn't have a narcotic card at all. RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have [MEDICATION(S)] on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if [MEDICATION(S)] was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the [MEDICATION(S)] because the resident was being sent home with a script for [MEDICATION(S)] anyway.When asked if it was acceptable for residents to not receive their ordered medications, RN #2 stated that it wasn't. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened to Resident #212's [MEDICATION(S)] on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's [MEDICATION(S)], LPN #1 stated that she did not. When asked if she attempted to pull the [MEDICATION(S)] from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the [MEDICATION(S)] from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of [MEDICATION(S)]. On 8/4/21 at 4:40 p.m., an interview was conducted with ASM (Administrative Staff Member) #4, the Nurse Practitioner. She could not recall being made aware that Resident #211 had missed all her doses of scheduled ordered [MEDICATION(S)]. ASM #4 stated that the physician may have been aware. ASM #4 stated that she expected the nursing staff to make her aware in order for her to give further direction. On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, Yes. When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's [MEDICATION(S)], ASM #2 stated that she didn't see where the [MEDICATION(S)] was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the [MEDICATION(S)] has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/21 at 11:19 a.m., an interview was conducted with ASM #5, the physician. He could not recall being made aware that Resident #211 had missed all her scheduled doses of [MEDICATION(S)]. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, Facility policy titled, Medication Shortage/Unavailable Medications documents in part, the following: Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified . 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. COMPLAINT DEFICIENCY

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a medical record review, facility document review and staff interviews the facility The facility staff failed to ensure a Notice of Medicare Non-Coverage was given timely prior to the last covered skilled day of 12/17/20 for 1 of 36 residents in the survey sample, Resident #59. The findings included: Resident #59 is a [AGE] year old admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #59's medical record indicated the resident was discharged home on 12/18/20 at 11:00 A.M. The most recent MDS (Minimum Data Set) for Resident #59 was a Discharge Assessment with a ARD (Assessment Reference Date) of 12/18/20. Resident #59's BIMS (Brief Interview for Mental Status) score was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #59's Notice of Medicare Non-Coverage (NOMNC) document with Skilled Nursing Services ending on 12/17/20 was reviewed and is documented in part, as follows: Page 1: The Effective Date Coverage if Your Current PT(Physical Therapy), OT(Occupational Therapy), ST(Speech Therapy) Services Will End: 12/17/20. Page 2: Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting QIO (Quality Improvement Organization). Signature of Resident #59 Date: 12/17/2020. Signature of Director of Social Services Date: 12/17/2020. A phone interview was conducted on 3/18/21 at 9:07 A.M. with the facility Social Worker regarding how far in advance should residents be provided a Notice of Medicare Non-Coverage. The Social Worker stated, If a resident is discharging you need to give the medicare notice three to five days before the discharge date . This gives the resident or family time to appeal, because they need to do their appeal before the services end. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted on 3/18/21 at approximately 10:15 A.M. with the Administrator, who was asked what were the expectations for issuing a Notice of Medicare Non-Coverage to residents. The Administrator stated, The notice should be given at least 48 hours prior to discharge so they have a chance to appeal. The facility policy titled Medicare Cut Letter Policy last revised on 1/29/2021 was reviewed and is documented in part, as follows: Policy: The Facility will assure all residents receive timely and appropriate notification of Medicare non-coverage for services in accordance with State and Federal guidelines. III. Delivery of Notice: All Notices are to be issued to the Resident/beneficiary or an authorized representative when the Resident is not capable of comprehending the Notice contents. Notice must be issues in accordance with the Triggering events and prior to the delivery of medical care which is presumed to be non-covered, a change or termination of services, but no later than 2 days prior to the change or termination. A pre-exit phone debriefing was conducted at 10:45 A.M. with the Administrator the the above information was reviewed. Prior to exit no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	03/18/2021

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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** Based on observation and staff interviews the facility's staff failed to maintain 1 of 36 residents (Resident #50), wheel chair in a clean and sanitary manner. The findings included: Resident #50 was originally admitted to the facility 12/3/14 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; [CONDITION(S)], diabetes and depression. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. On 3/17/21 at approximately 1:00 p.m., observation was made of Resident #50's wheel chair. A large amount of crumbs and other debris was observed on the side and beneath the seat cushion. An interview was conducted with Resident #50 on 3/17/21 at approximately 1:00 p.m. Resident #50 stated he wasn't aware of his wheel chair getting clean. He further stated no one comes to clean it. On 3/18/21 at approximately 11:00 a.m., again the debris was observed to the wheel chair therefore; an interview was conducted with Patient Care Assistant (PCA) #1. PCA #1 stated she would clean the debris from the resident's wheel chair. PCA #1 stated she was unaware of wheel chair cleaning schedules but she would find out. PCA #1 didn't return with the information. On 3/18/21 at approximately 7:00 p.m., the above findings were shared with the Administrator. The Administrator stated she would look further into the concern.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide evidence that care plan goals were sent with one of 36 residents (Resident #15) upon transfer to the hospital on 1/7/21. The findings included: Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #15's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 1/23/21. Resident #15 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that he was sent out to the hospital on 1/7/21 for a possible stroke. The following was documented in a nursing note dated 1/7/21: Resident at approximately 3pm resident noted with change in condition. He had difficulty speaking any words. Rt (right) side flaccid, unable to grasp with Rt hand. Unable to pull foot back and no response when rubbed bottom of right foot. He has a very strong grip with left hand and moving his left leg without difficulty. Call was placed to (Name of Nurse Practitioner), NP (Nurse Practitioner) and new orders to send him out 911. Attempted to call his 2 daughters, message left to return call to facility. Call placed to ED (Emergency Department) to give report, no answer at ED. Resident is his own responsible party. EMT's (Emergency Medical Technician) were made aware and that he is a full code. Review of Resident #15's Acute Care Transfer Document Checklist, also failed to show that Resident #15's care plan or care plan goals were sent with Resident #15 upon transfer to the hospital. Review of Resident #15's SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form dated 1/7/21 also failed to show that care plan goals were sent with Resident #15 at the time of transfer. Further review of Resident #15's clinical record revealed that he arrived back to the facility on [DATE] with a new diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] On 3/18/21 at 10:05 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #15's nurse. When asked what documents were sent with a resident upon transfer to a hospital, LPN #2 stated that nurses with send the facesheet, medication list, the transfer summary, and the bed hold policy. When asked if the care plan or care plan goals were sent with each resident upon transfer, LPN #2 stated, Care Plan goals, no, unless its part of the transfer summary. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. A policy could not be provided regarding the above concerns. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was presented prior to exit.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, staff interviews and complaint investigation, the facility staff failed to notify the Long Term Care Ombudsman of two residents (Resident #258 and #15) of transferring to the hospital in the survey sample of 36 residents. The findings included: 1. Resident #258 was admitted to the facility on [DATE]. This resident was diagnosed as having Tardue Dyskinesia, hypertension, anxiety, depression, [CONDITION(S)], [CONDITION(S)] disorder, [CONDITION(S)], and [CONDITION(S)]. the ombudsman was not notified of Resident #258 transfer to the hospital. This resident was assessed being stand to pivot x 1 assist, alert and oriented times 1 to self. Resident noted to wander in other patient rooms and exit seeking. A wander guard placed on left ankle. A Nursing note dated 06/03/20 at 5:38 P.M. indicated: Resident noted cursing loudly, screaming, and speaking to self. Resident noted pulling pants down, while walking in hallway. A Nursing note dated 06/04/20 at 6:48 P.M. indicated: 'Police arrived, in contact with local Community Service Board (CSB). Resident continue to be confused, yelling, and having hallucinations (talking to people who are not there). Resident does not follow directions, sitting on the floor, and then laid on the floor. Staff has made her environment secure. Resident's representative advised of status. A Nursing note dated 06/04/20 at 07:04 P.M. indicated: Resident laying on the floor, Emergency Transport arrived to transport to hospital. Physician advised of resident's status to transfer to hospital emergency department. During an interview on 03/17/21 at 4:50 P.M. with the social worker, she was asked if the Ombudsman was notified? The social worker responded, I did not notify the ombudsman. The facility staff failed to notify the ombudsman of Resident #258 transfer to the hospital. 2. Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #15's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 1/23/21. Resident #15 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's clinical record revealed that he was sent out to the hospital on 1/7/21 for a possible stroke. The following was documented in a nursing note dated 1/7/21: Resident at approximately 3pm resident noted with change in condition. He had difficulty speaking any words. Rt (right) side flaccid, unable to grasp with Rt hand. Unable to pull foot back and no response when rubbed bottom of right foot. He has a very strong grip with left hand and moving his left leg without difficulty. Call was placed to (Name of Nurse Practitioner), NP (Nurse Practitioner) and new orders to send him out 911. Attempted to call his 2 daughters, message left to return call to facility. Call placed to ED (Emergency Department) to give report, no answer at ED. Resident is his own responsible party. EMT's (Emergency Medical Technician) were made aware and that he is a full code. On 3/18/21 at 12:50 p.m., an interview was conducted with OSM (Other Staff Member) #3, social services. When asked the process for notifying the long term ombudsman regarding an acute care transfer, OSM #3 stated that she was only notifying the long term ombudsman for emergency transfers at the end of each month. When asked if she could present information that she notified the long term care ombudsman regarding Resident #15's transfer, OSM #2 stated that she just notified the long term care ombudsman regarding all January and February 2021 transfers on 3/17/21. OSM #3 stated that she was not aware that that was her responsibility; that the Director of Social Services was doing that; and that the facility no longer had a director. Review of an email dated 3/17/21 at 6:58 p.m., from the social worker to the ombudsman, revealed that the long term care ombudsman was not notified of Resident #15's transfer to the hospital until 3/17/21. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. Facility policy titled, Discharge/Transfer Letter Policy, documents in part, the following: Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. 1. Copies will be sent to the Department of Health, Ombudsman Office .For emergency transfers, one list can be sent to Ombudsman at the end of month.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, staff interviews and complaint investigation, the facility staff failed to provide two residents (Resident #258 and #15) with bed hold policy notice upon transfer to the hospital in the survey sample of 36 residents. The findings included: 1. Resident #258 was admitted to the facility on [DATE]. This resident was diagnosed as having Tardue Dyskinesia, hypertension, anxiety, depression, [CONDITION(S)], [CONDITION(S)] disorder, [CONDITION(S)], and [CONDITION(S)]. Resident #258 was not provided with a bed hold policy notice upon transfer to the hospital. This resident was assessed being stand to pivot x 1 assist, alert and oriented times 1 to self. Resident noted to wander in other patient rooms and exit seeking. A wander guard placed on left ankle. A Nursing note dated 06/03/20 at 5:38 P.M. indicated: Resident noted cursing loudly, screaming, and speaking to self. Resident noted pulling pants down, while walking in hallway. A Nursing note dated 06/04/20 at 6:48 P.M. indicated: 'Police arrived, in contact with local Community Service Board (CSB). Resident continue to be confused, yelling, and having hallucinations (talking to people who are not there). Resident does not follow directions, sitting on the floor, and then laid on the floor. Staff has made her environment secure. Resident's representative advised of status. A Nursing note dated 06/04/20 at 07:04 P.M. indicated: Resident laying on the floor, Emergency Transport arrived to transport to hospital. Physician advised of resident's status to transfer to hospital emergency department. During an interview on 03/17/21 at 4:45 P.M. with the social worker, she was asked if Resident #258 was provided with a bed hold policy notice? The social worker responded, I did not provide Resident #258 with a bed hold notice policy. The facility staff failed to provide Resident #258 with a bed hold policy notice upon transfer to the hospital. 2. Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #15's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 1/23/21. Resident #15 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. (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 - Few	Review of Resident #15's clinical record revealed that he was sent out to the hospital on 1/7/21 for a possible stroke. The following was documented in a nursing note dated 1/7/21: Resident at approximately 3pm resident noted with change in condition. He had difficulty speaking any words. Rt (right) side flaccid, unable to grasp with Rt hand. Unable to pull foot back and no response when rubbed bottom of right foot. He has a very strong grip with left hand and moving his left leg without difficulty. Call was placed to (Name of Nurse Practitioner), NP (Nurse Practitioner) and new orders to send him out 911. Attempted to call his 2 daughters, message left to return call to facility. Call placed to ED (Emergency Department) to give report, no answer at ED. Resident is his own responsible party. EMT's (Emergency Medical Technician) were made aware and that he is a full code. There was no evidence in the nursing notes that the bed hold policy was sent with Resident #15 at the time of transfer. Review of Resident #15's Acute Care Transfer Document Checklist, also failed to show that the bed hold policy was sent with Resident #15 upon transfer to the hospital. Review of Resident #15's SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form dated 1/7/21 also failed to show that the bed hold policy was sent with Resident #15 at the time of transfer. On 3/18/21 at 10:05 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #15's nurse. When asked what documentation was sent with a resident upon transfer to the hospital, LPN #2 stated that the bed hold policy was sent with each resident at the time of an acute care transfer. When asked if it should be documented what specific documents were sent with each resident at the time of a transfer, LPN #2 stated that nursing usually documents all of it. When asked how we would determine if a bed hold policy was sent with Resident #15 at the time of his transfer, if it is not documented in his clinical record, LPN #2 stated that she was not sure, that she would have to find out. On 3/18/21 at approximately 11:30 a.m., an interview was conducted with Resident #15. Resident #15 stated that because he was post having a stroke, he was not with it enough to remember if facility staff had gone over a bed hold policy with him at the time of transfer. On 3/18/21 at 1:17 p.m., an interview was conducted with OSM (Other Staff Member) #4, Admissions. When asked if the bed hold policy was discussed with each resident upon admission into the facility, OSM #4 stated that she will go over the admission packet, but does not go over the bed hold policy. OSM #4 stated that nurses were responsible for going over the bed hold policy upon transfer to the hospital. OSM #4 also stated that a hospital liaison will also go over that information with the resident or family while in the hospital; and the liaison will contact her with that information. When asked if she keeps documentation for each resident between her and the hospital liaison, OSM #4 stated that she did not; that these conversations were usually verbal over the telephone. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Discharge/Transfer Letter Policy, documents in part, the following: The resident or responsible party will receive a bed hold notice along with the discharge/transfer letter, when applicable.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, resident interview, staff interviews and clinical record review the facility staff failed to implement interventions, heel boots, in the comprehensive care plan for 1 of 36 Resident's in the survey sample, (Resident #6). The findings included: Resident #6 was originally admitted to the facility on [DATE]. The resident was discharged to the hospital on 02/23/2021 and readmitted to the facility on [DATE]. The resident was discharged to the hospital on 03/04/2021 and readmitted to the facility on [DATE]. diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #6's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 12/16/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #6 as requiring total dependence of 2 for bed mobility, dressing, toilet use, personal hygiene and bathing and supervision with set up help only for eating. On 03/17/2021 review of Resident #6's Clinical Record revealed the following: Review of [NAME] Braden Scale Pressure Ulcer Risk Assessment revealed the following: Effective Date: 12/17/2020 Braden Score: 13 Braden Category: Moderate Risk. Review of the Comprehensive Care Plan revealed the following: Focus; Heel Boots: Resident at Risk for impaired skin integrity impaired mobility. Goal: Skin will be free of breakdown. Interventions: Elevate heels off mattress per routine and/or as needed. Review of the Treatment Administration Record for the period of 03/01/2021 - 03/31/2021 revealed that Resident #6 has an order which reads as follows: Right heel - clean with Normal saline, apply [MEDICATION(S)], bordered dry dressing and wrap with kerlix every night shift. Start Date - 03/17/2021. On 03/18/2021 at approximately 12:05 p.m., requested that Certified Nursing Assistant (CNA) #4 pull back the covers from Resident #6 feet. After CNA #4 pulled the covers back and a pillow was observed under Resident #6's calves and the residents feet were crossed and her left heel was lying on the mattress. Observed right heel was wrapped with kerlix. CNA #4 stated, I had the pillow under her heels to float her heels. When asked how did the pillow get under Resident #6's calves, CNA #4 stated, She can move it. CNA #4 repositioned the pillow under Resident #6 lower legs to float the residents heels. Observed left heel to still be touching the mattress. When asked if Resident #6 wore heel boots, CNA #4 stated, I don't usually work over here. I worked with her yesterday and today. When asked if Resident #6 wore heel boots yesterday, CNA #4 stated, No. CNA #4 stated, I can get some heel boots and put them on her if you want. When asked how do you know what type care a resident needs, requires, CNA #4 stated, I get report and will ask what care to provide. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked what are your expectations of the staff, Director of Nursing stated, Should have on the heel poseys if its in the care plan. The facility did not present any further information about the finding.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, resident interview, staff interviews and clinical record review the facility staff failed to failed to revise the care plan with a change in code status for one of 36 residents; (Resident #14) AND failed to ensure that the intervention, compression glove, was included in the comprehensive care plan for one of 36 residents, (Resident #27). The findings included: 1. Resident #14 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #14's most recent MDS (Minimum Data Assessment) was a quarterly assessment with an ARD (assessment reference date) of 1/7/21. Resident #14 was coded as being severely impaired in the ability to make daily decision on the Staff Assessment for Mental Status exam. Review of Resident #14's March 2020 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . This order was initiated on 12/7/20. Review of Resident #14's facesheet documented Full Code as her code status. Review of Resident #14's care plan dated 2/18/21 documented the following: Resident has chosen DNR (Do Not Resuscitate). On 3/18/21 at 9:20 a.m., an interview was conducted with RN (Registered Nurse) #1, the MDS nurse. When asked who was responsible for revising the care plan, RN #1 stated that the floor nurses were responsible for revising the care plan for changes in the resident's status; but that MDS would review and revise the care plan quarterly. This writer showed RN #1 Resident #14's care plan. RN #1 stated that Resident #14's care plan should reflect Full Code and not DNR. RN #1 stated that Resident #14's care plan was inaccurate. RN #1 stated that Resident #14 used to be a DNR prior to 12/7/2020 and that it was not reflected on the care plan. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. Facility Policy titled, Comprehensive Care Planning, documents in part, the following: The MDS Coordinator is to review the 24 hour Report daily for significant changes or changes in resident's ADL (Activities of daily living) status. The Care Planning coordinator will add minor changes in resident's status to the existing Care Plans on daily basis. 2. Resident #27 was admitted to the facility on [DATE]. diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #27's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 02/13/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #27 as requiring total dependence of one person with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing and supervision with setup help only for eating. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/16/2021 at approximately 1:25 p.m. review of Resident #27's Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Revision Date: 03/04/2021. On 03/16/2021 at 2:00 p.m., conducted an interview with Resident #27. When asked if she could move her left arm, Resident #27 lifted her left arm and stated, Yes. When asked if she could move her right arm, Resident #27 stated, I can't move it as well I had a stroke. Resident #27's right hand observed to be edematous. Resident does not have on a compression glove. When asked if she wore the compression glove on her right hand, Resident #27 stated, I think I use to but not lately. On 03/17/2021 review of Resident #27's Clinical Record revealed the following: On 03/17/2021 Nurse Practitioner Progress Note was reviewed and revealed the following: Skin: sacral pressure ulcer, turgor normal, cap (capillary) refill < (less than) 3 sec (seconds), no cyanosis, warm dry, [CONDITION(S)] present to R arm and hand. On 03/17/2021 Admission Nurse Progress Note was reviewed and revealed the following: Effective Date: 2/10/2021 Type: Admission [CONDITION(S)] is present right arm and hand. On 03/17/2021 [NAME] Admission Readmission Evaluation was reviewed and revealed the following: Effective Date 02/10/2021 10. Cardiovascular A. [CONDITION(S)] Present A1. [CONDITION(S)] Describe: right arm and hand. On 03/18/2021 at approximately 1:30 p.m., received copy of Occupational Therapy Treatment Encounter Notes from Unit Manager. Review of Note signed on 3/8/2021 05:07: 55 PM revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: RUE (Right Upper Extremity) positioned elevated on pillows to decrease worsening [CONDITION(S)] in RUE. Unable to locate compression glove. Review of Note signed on 3/8/2021 05:07:56 PM revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: : Pt (Patient) re-issued R compression glove. donned with max (Maximum) A (Assist) to decrease [CONDITION(S)] in R (Right) hand. Retrograde massage completed to further reduce [CONDITION(S)] to increase R hand functional use in order to increase I with ADLs (Activities Daily Living). An interview was conducted with Registered Nurse (RN) #1, MDS Coordinator, when asked is the order for compression glove addressed in Resident #27's comprehensive care plan, RN #1 stated, I was not made aware of the order, I will care plan it. When asked should it be care planned, RN #1 stated, Yes, should be monitored and checked so it doesn't cut off circulation. The Administrator and Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked should the compression glove be addressed in the comprehensive care plan, Director of Nursing stated, Yes. When asked what is the purpose of the comprehensive care plan, Director of Nursing stated, Help guide the care to be provided to the resident.

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F 0658 Level of Harm - Minimal harm or potential for 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** Based on representative interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice by signing off medications were administered to two of 15 residents; Residents #212 and #211 that were not available. The findings included: 1. Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days. Review of Resident #212's July 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Start Date: 7/13/21 2100 (9 p.m.). Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p. m. dose of [MEDICATION(S)] on 7/13/21. Review of Resident #212's July 2021 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Evidence could not be shown that the nurses obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Omnicell list of medications revealed that [MEDICATION(S)] 50 mg was a medication available in the Omnicell. On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if [MEDICATION(S)] 50 mg was in the Omnicell, LPN #2 stated, Yes, I know that is in the STAT box. When asked if that is where she pulled Resident's #212's [MEDICATION(S)] on 7/14/21, LPN #2 stated, Yes, I pulled from the STAT box. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of [MEDICATION(S)] on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, I don't remember why I signed that off. When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, No ma'am. When asked what why the [MEDICATION(S)] had not made it to the facility, LPN #2 stated, I don't know exactly the cause. On 8/5/21 during a pre-exit meeting, ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility could not provide a policy or professional standard for the above concerns. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. 2. Resident #211 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated [DATE]. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's [MEDICATION(S)] (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to her stomach and feeling itchy all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed [MEDICATION(S)]. Resident #211's care plan dated 6/24/21 documented the following for pain: Resident is at risk for pain related to [CONDITION(S)] (Stroke) with right [CONDITION(S)] .Administer analgesics/medications per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] Review of Resident #211's June, July and August 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . This order was initiated on 6/24/21. Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that [MEDICATION(S)] was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m. Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of [MEDICATION(S)]. The first dose of [MEDICATION(S)] was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her [MEDICATION(S)] on 7/4/21 at 9:00 p.m.; where it was documented she had (zero) capsules left. Review of the second narcotic sheet for [MEDICATION(S)] revealed that pharmacy had delivered 30 capsules of [MEDICATION(S)] on 7/9/21. Resident #211's first dose of [MEDICATION(S)] was on 7/9/21 at 2100 (9:00 p.m.). There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13 administrations). Review of the facility STAT Omnicell list revealed that [MEDICATION(S)] 100 mg was in the Omnicell STAT box. Further review of Resident #211's July 2021 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 2 p.m. and 9 p.m. 7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m. 7/8/21 at 6:00 a.m. and 9:00 p.m. and 7/9/21 at 6:00 a.m. The following administration note was documented on 7/5/21 at 7:51 p.m.: On hold until received per NP (Nurse Practitioner). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following note was documented on 7/6/21 by the Nurse Practitioner: .Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting) .Neuropathy: Continue [MEDICATION(S)] ([MEDICATION(S)]) 100 mg TID, script renewed. On 7/7/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg- Give 1 mg by mouth three times a day for pain .pharmacy to send. On 7/8/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg .needs hard script. MD (medical doctor) aware. On 7/9/21 at 10:29 a.m., the following administration note was documented: [MEDICATION(S)] 100 mg three times a day for pain .per MD, administrator, DON (Director of Nursing) ok to give now. Further review of Resident #211's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 6:00 a.m., 7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m., 7/8/21 at 2:00 p.m. On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it was determined that the pharmacy did not receive a script for the [MEDICATION(S)] until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve [MEDICATION(S)] for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull [MEDICATION(S)] from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the [MEDICATION(S)] on the above dates. OSM #2 stated that the pharmacy initially sent out 28 capsules of [MEDICATION(S)] on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out [MEDICATION(S)] was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received [MEDICATION(S)] in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a. m. OSM #2 stated that the request to retrieve the [MEDICATION(S)] was made from the DON (Director of Nursing). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/21 at 5:00 p.m., an interview was conducted with the DON (Director of Nursing) (ASM (Administrative Staff Member) #2. When asked if there was has been issues obtaining scripts for narcotics or getting those scripts to the pharmacy; ASM #2 stated, Yes. When asked what had happened with Resident #211's [MEDICATION(S)] as the NP had documented that she wrote a script on 7/6/21; ASM #2 stated that she was unaware that Resident #211's [MEDICATION(S)] prescription had run out until the son had come into the building on 7/9/21. ASM #2 stated that he was upset that his mom had missed her [MEDICATION(S)] for several days and wanted to know what was going on with it. ASM #2 stated that she had called the medical doctor to obtain a script that day. ASM #2 stated that she pulled the medication out of the Omnicell and the nurse administered the medication, but could not remember the time. ASM #2 stated that she realized the resident had been out sometime before she initiated getting the resident her [MEDICATION(S)]. When asked if the son really had initiated obtaining his mom's medication, ASM #2 stated, Yes, it was in response to the son coming in. ASM #2 stated that she expected her nurses to follow up with [MEDICATION(S)] and not wait days later before obtaining the medication. ASM #2 stated that she was not sure what they did do, didn't do for the [MEDICATION(S)]. When asked if Resident #211 had an increase amount of pain related to missing 12 doses of [MEDICATION(S)], ASM #2 stated that she didn't think so, that this information was never reported to her. When asked if nursing staff should be documenting that medications are being administered when they are not in fact given, ASM #2 stated, Absolutely not. When asked if nursing staff should have pulled [MEDICATION(S)] from the Omnicell and administered the medication, ASM #2 stated that nursing staff could do that if there was a script for the medication. ASM #2 stated that she expected her staff to inquiring on why the gapabentin was not available and if it needed a script to call the physician, obtain a script and fax that to the pharmacy. ASM #2 stated that once the pharmacy has a script, the medication can be pulled from the Omnicell. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building with access. ASM #2 stated that she was not aware that not all nurses had access and didn't realize this was the responsibility of the DON to ensure their access. ASM #2 confirmed that all nurses should have access to the Omnicell if they are responsible for passing out medications, and that she was going to work on getting all nurses access. The nurses who had documented that they had administered the [MEDICATION(S)], when it was in fact, not administered could not be reached for an interview. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. (1) [MEDICATION(S)] is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/ 471/. COMPLAINT DEFICIENCY

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to accurately obtain, assess and monitor weights per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The findings included: 1. Resident #40 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #40's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 2/18/21. Resident #40 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam. Review of Resident #40's March 2020 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #40's care plan dated 12/30/2020 documented in part the following: Increased risk for nutrition problems r/t (related to) CHF (Congestive Heart Failure) .daily weights. Review of Resident #40's weights in his clinical record revealed that on 3/4/21 Resident #40 weighed 165.5 pounds. The next day (3/5/21) Resident #40 was documented as weighing 266.6 pounds (101.1 pound weight gain). Resident #40 was also documented as weighing 266 pounds on 3/6/21, 266.6 on 3/7/21, 266.1 on 3/8/21, 266 on 3/9/21, 201.7 on 3/12/21 and back down to 166.4 on 3/14/21. No weights were recorded for 3/10/21, 3/11/21, and 3/13/21. Review of Resident #40's clinical record revealed no indication that a re-weigh had been conducted due to the higher recorded weights from 3/5/21 through 3/12/21. There was no evidence that staff were monitoring Resident #40's weights. Review of the March 2021 MARS (Medication Administration Record) and TARS (Treatment Administration record) failed to evidence any additional weights obtained. On 3/17/21 at 3:25 p.m., an interview was conducted with CNA #2, a CNA on Resident #40's unit. When asked who was responsible for obtaining daily weights on residents, CNA #2 stated that the nursing aides were responsible. When asked how she obtains weights on residents who are totally dependent on staff for ADLS (Activities of daily living), CNA #2 stated that she would use the mechanical lift scale. When asked what she would do if she noticed a major discrepancy in a resident's weight; CNA #2 stated that she would alert the nurse or DON (Director of Nursing). When asked if she and the other nursing aides had been educated lately on how to accurately obtain weights, CNA #2 stated that she hadn't. On 3/18/21 at 9:30 a.m., an observation was conducted of CNA (Certified Nursing Assistant) #1 obtaining a daily weight on Resident #40 using a mechanical lift scale. There were no concerns related to obtaining his weight. Resident #40 weight was recorded as 164.6 (pounds). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/21 at 10:21 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #40's nurse. When asked why Resident #40 was on daily weights; LPN #2 stated that Resident #40 was on daily weights for his diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . When asked if there were parameters to notify the physician, LPN #2 stated that usually if a resident had a weight gain of 5 pounds in one week, she would notify the physician. When asked what would happen if a resident had a 100 pound weight gain in one day, LPN #2 stated that she would ask the CNAs (Certified Nursing Assistants) to do a reweigh. When asked if CNAs were responsible for obtaining daily weights, LPN #2 stated that the nursing aides obtain the weight and nurse enters in the weight into the system. When asked if the nurses were responsible for monitoring daily weights, LPN #2 stated that they were. When asked what had happened with Resident #40's weights from 3/5/21 through 3/12/21 documenting a 100 pound weight gain; LPN #2 stated the discrepancy must have been a error in documentation. When asked how an error was made six times on the clinical record, LPN #2 was not sure. LPN #2 stated that a re-weigh was probably done in response to the inaccurate weights. When asked if re-weighs should be documented on the clinical record, LPN #2 stated that re-weighs should be documented in a nursing note but that she didn't think Resident #40's re-weights were recorded. When asked how a resident can be assessed and monitored for daily weight gain if inaccurate weights are recorded in the clinical record and three days (3/10/21, 3/11/21, and 3/13/21) of the daily weights were missing; LPN #2 stated that she would have to find out that information. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. Facility policy titled, Weights Policy, documented in part, the following: D) Reweights: 1. For Residents who weigh > (greater) than 100#, all weight changes showing a gain or loss of 5 pounds or more from the previous weight require a reweigh within 24 hours. E) All significant weight changes must be communicated to the resident if appropriate, the attending physician and responsible party. F) Weight Documentation: 1. All weights for each Resident (Including, new admission, readmission, monthly, and weekly) are to be recorded in one central weight record. Appropriate methods for recording weights are: Electronic Health Record. Vital signs and Weight Record. 2. The facility staff failed to ensure heel boots were implemented per the person centered care plan.: Resident #6 was originally admitted to the facility on [DATE]. The resident was discharged to the hospital on 02/23/2021 and readmitted to the facility on [DATE]. The resident was discharged to the hospital on 03/04/2021 and readmitted to the facility on [DATE]. diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #6's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 12/16/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #6 as requiring total dependence of 2 for bed mobility, dressing, toilet use, personal hygiene and bathing and supervision with set up help only for eating. On 03/17/2021 review of Resident #6's Clinical Record revealed the following: Review of [NAME] Braden Scale Pressure Ulcer Risk Assessment revealed the following: Effective Date: 12/17/2020 Braden Score: 13 Braden Category: Moderate Risk. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan revealed the following: Focus; Heel Boots: Resident at Risk for impaired skin integrity impaired mobility. Goal: Skin will be free of breakdown. Interventions: Elevate heels off mattress per routine and/or as needed. Review of the Treatment Administration Record for the period of 03/01/2021 - 03/31/2021 revealed that Resident #6 has an order which reads as follows: Right heel - clean with Normal saline, apply [MEDICATION(S)], bordered dry dressing and wrap with kerlix every night shift. Start Date - 03/17/2021. On 03/18/2021 at approximately 12:05 p.m., requested that Certified Nursing Assistant (CNA) #4 pull back the covers from Resident #6 feet. After CNA #4 pulled the covers back and a pillow was observed under Resident #6's calves and the residents feet were crossed and her left heel was lying on the mattress. Observed right heel was wrapped with kerlix. CNA #4 stated, I had the pillow under her heels to float her heels. When asked how did the pillow get under Resident #6's calves, CNA #4 stated, She can move it. CNA #4 repositioned the pillow under Resident #6 lower legs to float the residents heels. Observed left heel to still be touching the mattress. When asked if Resident #6 wore heel boots, CNA #4 stated, I don't usually work over here. I worked with her yesterday and today. When asked if Resident #6 wore heel boots yesterday, CNA #4 stated, No. CNA #4 stated, I can get some heel boots and put them on her if you want. When asked how do you know what type care a resident needs, requires, CNA #4 stated, I get report and will ask what care to provide. The Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked what are your expectations of the staff, Director of Nursing stated, Should have on the heel poseys if its in the care plan. The facility did not present any further information about the finding. 3. The facility staff failed to ensure that Resident #27 was wearing a compression glove to the right hand per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] Resident #27 was admitted to the facility on [DATE]. diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #27's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 02/13/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #27 as requiring total dependence of one person with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing and supervision with setup help only for eating. On 03/16/2021 at approximately 1:25 p.m. review of Resident #27's Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Revision Date: 03/04/2021. On 03/16/2021 at 2:00 p.m., conducted an interview with Resident #27. When asked if she could move her left arm, Resident #27 lifted her left arm and stated, Yes. When asked if she could move her right arm, Resident #27 stated, I can't move it as well I had a stroke. Resident #27's right hand observed to be edematous. Resident does not have on a compression glove. When asked if she wore the compression glove on her right hand, Resident #27 stated, I think I use to but not lately. On 03/17/2021 review of Resident #27's Clinical Record revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/17/2021 Nurse Practitioner Progress Note was reviewed and revealed the following: Skin: sacral pressure ulcer, turgor nml, cap (capillary) refill < (less than) 3 sec (seconds), no cyanosis, warm dry, [CONDITION(S)] present to R arm and hand. On 03/17/2021 Admission Nurse Progress Note was reviewed and revealed the following: Effective Date: 2/10/2021 Type: Admission [CONDITION(S)] is present right arm and hand. On 03/17/2021 [NAME] Admission Readmission Evaluation was reviewed and revealed the following: Effective Date 02/10/2021 10. Cardiovascular A. [CONDITION(S)] Present A1. [CONDITION(S)] Describe: right arm and hand. In at Resident #27 bedside on 03/17/2021 at approximately 1:45 p.m., did not observe compression glove on right hand. On 03/18/2021 at approximately 9:40 a.m., in at Resident #27's bedside and did not observe compression glove on right hand. On 03/18/2021 at approximately 10:00 a.m., requested that the Unit Manager, accompany surveyor to Resident #27's bedside. Resident lying in bed with eyes open. Requested that Resident #27 show us her right hand. Observed edematous right hand. When Unit Manager was asked if Resident #27 should be wearing a compression glove on the right hand, Unit Manager stated, I will have to check. After departing Resident #27's room the physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . The Unit Manager stated, I can't remember, she may have refused to wear the glove. I will have to check. The Unit Manager was made aware that during the period of 03/16/2021 through 03/18/2021 the resident had not been observed wearing the glove. On 03/18/2021 at approximately 1:30 p.m., received copy of Occupational Therapy Treatment Encounter Notes from Unit Manager. Review of Note signed on 3/8/2021 05:07: 55 PM revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: RUE (Right Upper Extremity) positioned elevated on pillows to decrease worsening [CONDITION(S)] in RUE. Unable to locate compression glove. Review of Note signed on 3/8/2021 05:07:56 PM revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: : Pt (Patient) re-issued R compression glove. donned with max (Maximum) A (Assist) to decrease [CONDITION(S)] in R (Right) hand. Retrograde massage completed to further reduce [CONDITION(S)] to increase R hand functional use in order to increase I with ADLs (Activities Daily Living). On 03/18/2021 at approximately 1:40 p.m., an interview was conducted with the Unit Manager, when asked if Resident #27 should be wearing a compression glove on the right hand, Unit Manager stated, Yes. The Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked what are your expectations of the staff, Director of Nursing stated, They should make sure to have the glove on as ordered. The facility did not present any further information about the finding.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a complaint investigation, observations, staff and resident interviews and facility documentation, the facility staff failed to provide care and services to prevent pressure ulcers prior to identification at an advanced stage for 2 of 36 residents (R#13 and #408) in the survey sample which constituted harm for both residents. Resident #13's sacral pressure ulcer was first identified on 3/18/21 by senior nursing management as unstageable, as well as Resident #408's sacral pressure ulcer first identified on 3/7/20 at a Stage III. The findings included: 1. Resident #13 was admitted [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The Admission Minimum Data Set (MDS) assessment was dated 1/5/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact with the cognitive skills for daily decision making. The resident was coded to require limited assistance of one person for bed mobility, and extensive assistance from one staff for transfers, dressing, personal hygiene, toilet use and bathing. The resident was not assessed to have pressure ulcers. The resident was coded for Hospice upon admission. Resident #13 was coded continent of bowel and bladder. The care plan dated 12/30/20 and revised on 3/18/21 identified that the resident was at risk for the development of pressure ulcers. The goal set by the staff for the resident was that she would maintain intact skin. Some of the approaches the staff would implement to accomplish this goal included complete Braden Scale per protocol, skin assessments per protocol, use pressure releasing devices as indicated, turn and reposition as indicated and diet as indicated. The care plan dated 3/18/21 also identified actual skin breakdown, unstageable. The goal set by the staff for the resident was that she would have no further preventable skin breakdown thru next review. Some of the approaches the staff would implement to accomplish this goal were to add an air mattress, treatment initiated on 3/18/21 and notify medical doctor if treatment was ineffective. The Braden scale dated 1/13/21 scored the resident with a score of 17 that indicated Resident #13 was at risk for pressure ulcers, need to implement preventative interventions. The significant areas on the Braden Scale were in sensory perception, activity, mobility and friction and shear. Some of the preventative interventions that should address these specific areas and would include skin assessment and inspection every shift, regular turning schedule, enable as much activity as possible, protect heels, use pressure redistribution surfaces, nutrition consult (supplements, monitor intake, small frequent meals) and advance to a higher level of risk if other major risk factors are present (information obtained on 3/19/21 from reference dated 2014 https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/pressure_ulcer_prevention/webinars/webinar5_pu_riskassesst-tools.pdf). Review of The Bi-Weekly Skin Checks dated 3/5/21, 3/8/21, 3/11/21, 3/14/21 and 3/17/21 indicated Resident #13 did not have any current or newly identified skin issues. The following observations were made of Resident #13: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/16/21 at approximately 12:30 p.m., the resident was in bed with lunch tray on overbed table. On 3/16/21 at approximately 3:00 p.m., the resident was again observed in bed lying on a regular pressure reducing mattress. During the interview with the resident she was asked if there was anything this surveyor could do for her, to which she responded, I feel like something different is going on with my tailbone, maybe it is due to a fall I had, but I am not sure. I did fall out of bed straight on my [NAME]. They put cream on where I hit on the floor, but over the last couple of weeks, the pain continues a couple hours later. Now, it is giving me a fit, but I will get some more cream tonight, but it is not going to last. The Treatment Administration Record (TAR) indicated that the cream the resident was referring to was *Lidocaine 4 percent (%) to right hip and sacrum three times a day, ordered by the physician on 3/2/21. The fall the resident experienced was on 2/10/21 with no identified injuries or fractures from assessment and X-rays. *Lidocaine 4% cream is a non-greasy cream specially formulated with soothing agents, indicated as a topical anesthetic for use on normal intact skin for local [MEDICATION(S)] (Retrieved on 3/22/21 from reference dated 2019 https://dailymed.nlm.nih.gov/dailymed/drugInfo. cfm?setid=a3216e25-82bb-4905-ac0b-b2ef4aa32ea0). On 3/17/21 at approximately 11:30 a.m., Resident #13 was again observed in bed. When asked how her bottom was she stated, If you do anything for me today, please have someone check my bottom, it hurts worse and worse. This is what hurts me the most now. I am trying to stay off it as best as I can. I have told my nurse, but I need them to do something other than pain medication. The pain assessment documentation indicated that the resident scored her pain on 3/17/21 for the 7:00 a.m. to 7:00 p.m. shift at a 6 out of a possible score of 10 (moderately strong pain). This surveyor approached LPN #3 and relayed the resident's complaint about her bottom. The LPN stated she would do a full skin assessment before she finished her shift at 7:00 p.m. LPN#3 filled out a Bi-Weekly Skin Check signed off on 3/17/21 at 3:02 p.m. that there were no current or new skin issues. No further nurse's notes were written by LPN #3. On 3/18/21 at 1:10 p.m., Resident #13 was observed in bed. Certified Nursing Assistant (CNA) #3 and LPN #5, who was giving the resident medications, were at the bedside. When asked how the resident was feeling, she stated, Last night a nurse put a wonderful pad on my bottom and it felt glorious, but I think it needs to be changed because it is crumpling up and starting to hurt again. CNA#3 assisted the resident to turn on her left side and a large pink foam boarded dressing was on the resident's sacral area. The distal portion of the dressing was crumpled, which enabled the CNA to peel it back and spread her buttocks. An obvious open area was identified on the resident's sacrum. The CNA said she was assigned the resident, but did not remove the pink dressing. LPN #5 also looked and stated, I have only been here 3 days. I don't know what that is. I am from the agency and I am not qualified to assess this. The LPN did not contact another nurse to assess the open area. The resident was wearing a brief and stated that sometimes she is incontinent of urine. The resident was not assessed or care planned for incontinence. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/18/21 at 1:40 p.m., the aforementioned concerns were shared with the Director of Nursing (DON). She stated that she nor the Unit Manager (UM) LPN #1 were made aware by any aide or nurse of the resident's complaints about her bottom or that there was an open area on the resident's sacrum, but all licensed nurses were able to assess and stage wounds. The DON said she was going to check with the agency to find out what their skills were related to assessing alteration in skin integrity to include pressure ulcers. It was shared with the DON that this surveyor told LPN #3 specifically about the resident's complaint on 3/17/21 and that the LPN stated she would complete a full skin assessment. The information was also shared with the DON that someone put a large pink foam dressing on the resident's sacrum as observed on 3/18/21 at 1:10 p.m. During the above interview, the DON called LPN #3 and asked if she performed a full skin assessment on 3/17/21 to include the resident's bottom and sacral area. LPN #3 said, I tilted her propped up some pillows at her back and gave her some pain medication, but I did not spread her buttocks to assess her sacral area. The LPN stated she was not the nurse that placed a pink foam dressing on the resident's sacrum. LPN #3 was the nurse that completed the Bi-Weekly Skin-Check dated 3/17/21 that indicated no current or new skin issues were identified. At no time did this surveyor give an opinion to the DON regarding the area identified, so that she could make her own assessment without any influence. On 3/18/21 at 15:01 p.m., the DON assessed the resident's skin to identify an *unstageable sacral pressure ulcer with 100% yellow (slough/soft dead tissue) wound bed that was not present upon admission, 0.4 centimeters (cm) length by (x) 0.3 cm width and 0.1 depth. with periwound appearance red. The DON documented that the resident's pain level was a 6 out of a possible score of 10. A physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The DON stated she would apply a smaller foam dressing that would conform to the resident's sacral area. The DON stated she found out from the 7:00 p.m. (3/17/21) to 7:00 a.m. (3/18/21) LPN #7 that said she did not see an open area on the resident's sacrum, and only applied a pink foam pad, without an order, for comfort because the resident stated her bottom was hurting. On 3/18/21 at 4:14 p.m., a debriefing was held with the Administrator, DON and Regional Vice President of Operations (RVPO). The UMLPN #1 stated that she expected the nurses to have informed her of Resident #13's consistent complaints of sacral pain that was different from her normal pain, but she was not made aware. The UMLPN#1 stated, The purpose of the bi-weekly skin assessments is to identify any skin problems early that are quickly treatable. It was a consensus of the group that it was acceptable to first identify pressure ulcers at an advanced stage. The DON said all in house regular mattresses are pressure reducing, and she would be communicating with Hospice to obtain an air mattress for Resident #13. They stated they have standards of care meetings in the morning, but did not have one on 3/18/21, but staff could have passed on the resident's complaints and notified the Unit Manager or the DON. The DON and the Regional Administrator stated It is obvious, we need to do some training. On 3/18/21 at 5:15 p.m., Resident #13 was observed in bed and stated she was thankful that she finally knew what the problem was and treatment would heal the area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/18/21 at approximately 5:30 p.m., the DON stated she called the Hospice nurse to ask if when she came to see the resident, on 3/18/21 at 11:30 a.m., did she identify the pressure ulcer on the resident's sacrum. According to the DON, the Hospice nurse said she completed a full skin assessment and did not identify any pressure ulcer, but she was on her way back to nursing facility. The DON stated, It is clear that it that a thorough skin assessments are not being performed by the nurses to include the Hospice nurse, especially along with the resident's complaint of pain in that area where the pressure ulcer was located. Because of the laxity of her skin, they needed to have spread her buttocks apart, not just turn her and take a look. You would not see anything otherwise. On 3/18/21 at approximately 6:45 p.m., the RVPO presented an action plan with Root Cause Analysis for pressure ulcers that identified Not repositioning every 2 hours, increase in agency usage and early identification. It incorporated education of clinical staff on the importance of turning and repositioning residents, educate clinical staff on pressure ulcer staging, including agency staff and to educate C.N.A. to inform nurses of any identified skin issues. The following information was retrieved on 3/22/21 from the 2020 National Pressure Injury Advisory Panel (NPIAP) www.npiap.com 1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. Inspect the skin at least daily for early signs of pressure injury, especially nonblanchable [CONDITION(S)]. Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible. Refine the assessment by including these additional risk factors: Fragile skin. Existing pressure injury of any stage, including those ulcers that have healed or are closed. Pain in areas of the body exposed to pressure Repeat the risk assessment at regular intervals and with any change in condition. 3. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface . Consider level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface. Continue to reposition an individual when placed on any support surface. Use a breathable incontinence pad when using microclimate management surfaces. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. The facility's staff failed to identify Resident #408's sacral pressure ulcer until it advanced to a stage 3 deteriorating to unstageable by 3/12/20 and the facility staff failed to demonstrate it was unavoidable. Resident #408 was originally admitted to the facility 2/6/20. The Resident's diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/3/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #408's cognitive abilities for daily decision making were moderately impaired. In section G (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, personal hygiene, bathing, dressing, and toileting, and supervision after set-up with eating. Resident #408 was no longer a resident of the facility therefore; a closed record review was conducted. Resident #408 had the following risk factors for skin breakdown; fragile skin, a low body weight with fair intake, decreased bed mobility related to a fractured right tibial plateau, and episodes of incontinence. Review of the resident's current care plan dated 2/19/20, addressed skin tears only not a potential for pressure ulcers or an actual pressure ulcer was present, with a goal date through 5/19/20. The problem read; (name of resident) has impaired skin integrity as evidenced by skin tears to the right forearm. The goal read; Resident will demonstrate improvement of skin integrity within 30 days 5/19/20. The interventions included; encourage meal consumption and fluid intake, monitor nutritional parameters, assist resident to eat/drink an adequate amount of nutrition, monitor lab values, follow prescribed treatment regimen, protective measures when in chair or bed, observe skin condition daily for skin excoriation, apply protective undergarments/pads, avoid constricting clothes, use bed cradle, foam mattress to avoid skin breakdown, provide adequate hydration, provide adequate nutrition, vitamins, protein carbohydrates, avoid pressure on extremities with skin protectors, assess actual areas of breakdown and document on skin sheet, keep skin clean and dry, position resident for comfort and minimal pressure on bony prominences. Braden and Skin assessments were requested for Resident #408, but only skin assessments dated 3/9/20, 3/22/20 and 3/31/20 were provided after multiple request. The 3/9/20 Daily Skilled Nurse's Note skin assessment was coded for abnormal skin color, macerated bottom and turn and reposition. The 3/22/20 skin assessment was coded for having fair, pale and moist skin, skin [CONDITION(S)] or open wounds, bruises and ecchymosis. A 3/31/20, Daily Skilled Nurse's Note skin assessment was coded for assessment pressure ulcers only. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nurses's note dated 3/7/20 at 6:40 p.m., revealed the resident required one person assistance with activities of daily living, and the resident uses a bedpan but experiences episodes of incontinence. The nurse's note also stated the resident was identified with a facility acquired stage 3 pressure ulcer measuring 3 centimeters x 2 centimeters. The wound care assessment dated [DATE] further described the sacral pressure ulcer as having 70% granulation tissue and 30% soft adherent necrotic tissue. The 3/7/20 pressure ulcer assessment further revealed the sacral pressure was with moderate serosanguineous exudate with distinct and attached edges. The following order was obtained; clean the wound to the sacrum with normal saline, apply calcium alginate, cover with Allevyn. The sacral wound's etiology was determined to be pressure related and the pressure ulcer continued to deteriorate based on the wound care physician assessment dated [DATE]. It measured 2.2 centimeters by 1. 6 centimeters, and was unstageable as revealed by 70% thick adherent black necrotic tissue (eschar) and 30% thick adherent devitalized necrotic tissue. Surgical excision of the devitalized and necrotic subcutaneous tissue was performed. A new treatment order was ordered by the wound care physician, it read; clean the wound with normal saline, apply Santyl ointment, apply Dakins moist gauze and cover. The wound care physician's progress note also stated the resident verbalized pain of a 6 out of 10. The wound care physician offered further recommendations to off-load the wound, reposition the resident per facility protocol and use of a low air loss mattress. On 3/18/20 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. An opportunity was offered to the facility's staff to present additional information. It appears in the body of this writing. Assessment 1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission). 3. Refine the assessment by including these additional risk factors; Fragile skin, Existing pressure injury of any stage, including those ulcers that have healed or are closed, Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use, Pain in areas of the body exposed to pressure. 4. Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels: Acute care . Every shift, Long term care . Weekly for 4 weeks, then quarterly, Home care . At every nurse visit (https://npiap.com/general/custom.asp?page=PreventionPoints) 5. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems. Preventing pressure ulcers (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Pressure ulcers 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. When this happens, a pressure ulcer may form. You have a risk of developing a pressure ulcer if you: · Spend most of your day in a bed or a chair with minimal movement · Are overweight or underweight · Are not able to control your bowels or bladder · Have decreased feeling in an area of your body · Spend a lot of time in one position You will need to take steps to prevent these problems; You, or your caregiver, need to check your body every day from head to toe. Pay special attention to the areas where pressure ulcers often form. These areas are the: · Heels and ankles, Knees, Hips, Spine, Tailbone area, Elbows, Shoulders and shoulder blades, Back of the head Ears. After urinating or having a bowel movement; Clean the area right away. Dry well., Ask your provider about creams to help protect your skin in this area. *Call your health care provider if you see early signs of pressure ulcers. These signs are: Skin redness, Warm areas, Spongy or hard skin, Breakdown of the top layers of skin or a sore. (https://medlineplus.gov/ency/patientinstructions/ 7.htm) *Unstageable pressure ulcer/injury is a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage III or Stage IV pressure injury will be revealed (retrieved on 3/22/21 from document Prevention and treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . 42, 2019). *Dakins solution is a dilute sodium [MEDICATION(S)] (NaClO) solution that is commonly known as bleach. The mixture of sodium peroxide (NaO) and [MEDICATION(S)] acid (HCl) produces sodium [MEDICATION(S)]. It has a solvent action on dead cells that hastens the separation of dead tissue from living tissue (retrieved on 3/22/21 from reference dated 2021 https://www.ncbi.nlm.nih.gov/books/NBK 6/). COMPLAINT DEFICIENCY

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to ensure [MEDICATION(S)] measures were provided to one of 15 residents in the survey sample, Resident #212 who requested pain medication on 7/13/21 and 7/14/21. The findings included: Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of Resident #212's medical record revealed that Resident #212 had an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident #212's July TAR (Treatment Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for [MEDICATION(S)]. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. There was no evidence on Resident #212's MAR (Medication Administration Record) that nursing administered prn (as needed) Tylenol to Resident #212 on 7/13/21. There was no evidence of any non-pharmacological [MEDICATION(S)] measures provided to Resident #212 on 7/13/21. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o (complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days. Further review of Resident #212's MAR revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p.m. dose of [MEDICATION(S)] on 7/13/21. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a therapy note dated 7/14/21 documented in part, the following: .reported increased R knee pain . Pt left sitting up in wc (wheelchair) and NRSG (nursing) arriving to administer pain meds .Pt reported 7/10 p in R knee, NRSG made aware that pt requested pain meds. Review of Resident #212's MAR revealed that there was no evidence that nursing administered administered prn (as needed) Tylenol to Resident #212 on 7/14/21. There was no evidence of any non-pharmacological [MEDICATION(S)] measures provided to Resident #212 on 7/14/21. Further review of the July MAR revealed that a nurse had signed off that she had administered the scheduled [MEDICATION(S)] at 9:00 a.m. Evidence (Narcotic sheets) could not be provided to show that the ordered [MEDICATION(S)] had made it to the facility from pharmacy. Evidence could not be shown that the nurse obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's pain care plan dated 7/2/21 documented the following: The resident has pain r/t (related to) Right knee pain AEB closed fracture of right tibial plateau, Osteroarthritis .Administer analgesics per orders, Anticipate the patient's need for [MEDICATION(S)] and respond to any complaint of pain as needed. Assess/document for probable cause of each pain episode. Remove/limit causes where possible . On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. On 8/5/21 at 10:41 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on both 7/13/21 and 7/14/21. When asked if she recalled therapy speaking to her about Resident #212's increased pain on both 7/13/21 and 7/14/21; LPN #2 stated that she didn't recall specific days but that they usually let her know. When asked if she provided any [MEDICATION(S)] measures to Resident #212 on 7/13/21 and 7/14/21 after therapy had alerted her of Resident #212's pain; LPN #2 stated, I don't remember. When asked if medications are usually signed off on the MAR after they are administered, LPN #2 stated that medications are to be signed off after they have been administered. This writer showed LPN #2 Resident #212's MAR and the lack of evidence that PRN medication was administered. LPN #2 stated, I must not have given it then. When asked how she signed off that she had administered a 9 a.m. dose of [MEDICATION(S)] on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, I don't remember why I signed that off. When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, No ma'am. When asked if non-pharmacological interventions rendered for pain should be documented, LPN #2 stated that it should. LPN #2 stated again that she wasn't sure what happened, that sometimes therapy makes the pain sound bigger than it is and maybe she asked the resident and the resident was fine. LPN #2 could not provide evidence of a pain assessment conducted for Resident #212 on 7/13/21 and 7/14/21. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/21 at 11:19 a.m., an interview was conducted with OSM #4, the PTA (Physical Therapy Assistant) who worked with Resident #212 on both 7/13/21 and 7/14/21. OSM #4 stated that the first day she had worked with the resident, the resident had declined her therapy due to pain. OSM #4 stated that the second day, Resident #212 was still having pain to that right knee but was able to participate some in therapy. OSM #4 stated that she had alerted the nurse on duty both times regarding her pain. OSM #4 stated that she could not specify who she had told. When asked if she had actually seen the nurse administer pain medication or provide non-pharmacolgical relief interventions; to Resident #212, OSM #4 stated that she did not witness that. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility could not provide a policy or professional standard for the above concerns. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. COMPLAINT DEFICIENCY

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review the facility staff failed to ensure that 1 of 36 residents (Resident #10) in the survey sample had an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The findings included: Resident #10 was admitted to the facility on [DATE]. Resident #10 was discharged to the hospital on 02/25/2020 and readmitted to the facility on [DATE]. diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #10's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/18/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #10 as requiring supervision with setup help only with eating, limited assistance of 1 with bed mobility, dressing, toilet use and personal hygiene, extensive assistance of 1 with transfer and physical help in part of bathing activity with assistance of 1. On 03/17/2021 review of Resident #10's Clinical Record revealed the following: Review of Resident #10's Comprehensive Care Plan revealed the following: Resident receives [CONDITION(S)] treatments 3 times weekly. [CONDITION(S)] ([CONDITION(S)]). Date Initiated: 12/15/2020 Created on: 12/15/2020 Revision on: 12/15/2020. Review of Resident #10's Order Summary Report on 03/17/2021 at approximately 2:10 p.m., revealed the following date: Active Orders As Of: 03/01/2021. Review of Order Summary Report did not evidence an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 03/18/2021 review of Resident #10's Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . On 03/18/2021 review of Resident #10's Treatment Administration Record for the period of 03/01/2021 - 03/31/2021 did not evidence an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 03/18/2021 at approximately 3:45 p.m., at pre-exit meeting the Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding. When asked should the resident have an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . When asked who obtains the order, The nurse. When asked what are your expectations of the nurses, Director of Nursing stated, Expect them to follow up to get the order. The facility did not present any further information about the finding.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility staff failed to acquire medications upon admissions for one resident (Resident #258) in the survey sample of 36 residents. The findings included: Resident #258 was admitted to the facility on [DATE]. This resident was diagnosed as having Tardue Dyskinesia, hypertension, anxiety, depression, [CONDITION(S)], [CONDITION(S)] disorder, [CONDITION(S)], and [CONDITION(S)]. The facility staff failed to acquire medications upon admissions for Resident #258. This resident was assessed being stand to pivot x 1 assist, alert and oriented times 1 to self. Resident noted to wander in other patient rooms and exit seeking. A wander guard placed on left ankle. Resident #258 had a physician's order dated 06/03/20 for the following medications: [MEDICATION(S)] 35 milligrams (mg) tablet (1 tablet) oral one time weekly starting 06/03/20: [MEDICATION(S)] 0.005% eye drops (1 drop) drops both eyes one time daily starting 06/03/20: [MEDICATION(S)] 2 mg tablet (1 tablet) tablet oral two times daily starting 06/03/20: [MEDICATION(S)] sulfate 325 mg (65 mg iron) tablet (1 tablet) tablet oral two times daily starting 06/03/20: [MEDICATION(S)] 0.5 mg tablet (1 tablet) tablet oral two times daily starting 06/03/20: [MEDICATION(S)] 1 mg tablet (1 tablet) tablet oral two times daily starting 06/03/20: [MEDICATION(S)] 10 mg tablet (1 tablet) tablet oral one time daily starting 06/04/20: [MEDICATION(S)] 10 mg tablet (1 tablet) tablet oral one time daily starting 06/04/20: A review of the Medication Administration Record June 2020 Non-PRN Medication Notes indicated: [MEDICATION(S)] 2 mg tablet (1 tablet) tablet oral two times daily - Date 06/03/20 - Time 2100 (9:00 P.M.) Notes- Not administered (Med not available). A 06/04/20 note indicated: Time- 9:00 A.M. -Notes - Not administered (Med not available). During an interview on 03/18/21 at 9:07 A.M. with the Director of Nursing (DON) she stated, Resident #258 did not receive her prescribed [MEDICATION(S)] 2 mg medications on 06/03/20 and 06/04/20 was because the meds were not available. A facility Pharmacy Services policy Medication shortages/Unavailable Medications indicated: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedures: 1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 of this policy as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply facility staff should notify pharmacy and arrange for an emergency delivery. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery: or 3.2.2 Use of an emergency (back-up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. During an interview on 03/18/21 at 9:07 A.M. with the DON she stated, The Stat Box information was not available for review because of a lack of access with the prior owner's of the facility. The facility staff failed to acquire medications upon admission to the facility for one resident. Based on resident interview, staff interviews and review of facility documents, the facility's staff failed to consistently procure an ordered significant medication for 1 of 36 residents (Resident #50), in the survey sample. The findings included (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #50 was originally admitted to the facility 12/3/14 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; [CONDITION(S)] (MS). The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. An interview was conducted with Resident #50 on 3/16/21 at approximately 12:40 p.m. Resident #50 stated frequently his [CONDITION(S)] medication Glatiramer 20 milligram/1 milliliter subcutaneously is not available for administration. The resident further stated he wasn't sure why the staff allowed it to run out prior to obtaining more. The physicians order dated 12/15/20 read; Glatiramer 40 milligram/1 milliliter subcutaneously one time per day on Monday, Wednesday and Friday, for MS. On 2/24/21, the order was resumed after the resident returned from the hospital. Review of the pharmacy invoices provided revealed the pharmacy delivered a one week supply (3 one dose syringes) of the medication to the facility 12/23/20 and doses were administered 12/25/20, 12/28/20 and 12/30/20, Three more doses were delivered 12/28/20 to be administered 1/1/21, 1/4/21 and 1/6/21, Three more doses were delivered 1/7/21 and administered 1/8/21, 1/11/21 and 1/13/2, Three more doses were delivered 1/15/21 and were administered 1/15/21, 1/18/21 and 1/20/21, Three more doses were delivered 1/20/21 and were administered 1/22/21, 1/25/21 and 1/27/21, there was no medication available to administer 1/27/21 and 1/29/21 for the next three more doses were not delivered until 2/3/21, they were administered 2/3/21, 2/5/21 and 2/8/21, there was no medication available to administer 2/10/21, Three more doses were delivered 2/12/21, they were administered 2/12/21, 2/15/21 and one left for 2/17/21 but the resident was admitted to the hospital on 2/16/21. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 3/18/21 at approximately 1:45 p.m. LPN #2 stated there has been occurrences in which the resident's medication Glatiramer had been delivered late to the facility or not available to administer at all but less frequently than previously. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated she would look further into the allegation and provide documentation after it was obtained. Pharmacy invoices for the medication Glatiramer 40 milligram/1 milliliter were requested from 11/1/21 through the last delivery 3/16/21. Invoices for three doses were provided for 11/18/20, 11/30/20, 12/6/20 .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on representative interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure medications were procured for two of 15 residents in the survey sample; Resident #212 and #211. The findings included: 1. Resident #212 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain. Review of Resident #212's medical record revealed that Resident #212 had an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for pain relief. Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part, .Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time .Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware. Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable . 1. Right knee pain: will give [MEDICATION(S)] (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days. Review of Resident #212's July 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Start Date: 7/13/21 2100 (9 p.m.). Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her [MEDICATION(S)] was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p. m. dose of [MEDICATION(S)] on 7/13/21. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #212's July MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Evidence could not be shown that the nurses obtained the ordered [MEDICATION(S)] from the Omnicell (STAT box). Review of Resident #212's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m. Review of the Omnicell list of medications revealed that [MEDICATION(S)] 50 mg was a medication available in the Omnicell. On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview. On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if [MEDICATION(S)] 50 mg was in the Omnicell, LPN #2 stated, Yes, I know that is in the STAT box. When asked if that is where she pulled Resident's #212's [MEDICATION(S)] on 7/14/21, LPN #2 stated, Yes, I pulled from the STAT box. On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive her ordered [MEDICATION(S)] on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that. On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled [MEDICATION(S)] on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, Yes. When asked if this included scheduled pain medications, RN #2 stated, Yes. When asked why Resident #212 did not receive her scheduled [MEDICATION(S)] on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, She didn't have [MEDICATION(S)]. When asked what she had meant by that statement, RN #2 stated, She didn't have a narcotic card at all. RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have [MEDICATION(S)] on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if [MEDICATION(S)] was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the [MEDICATION(S)] because the resident was being sent home with a script for [MEDICATION(S)] anyway.When asked if it was acceptable for residents to not receive their ordered medications, RN #2 stated that it wasn't. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened to Resident #212's [MEDICATION(S)] on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's [MEDICATION(S)], LPN #1 stated that she did not. When asked if she attempted to pull the [MEDICATION(S)] from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the [MEDICATION(S)] from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of [MEDICATION(S)]. On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, Yes. When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's [MEDICATION(S)], ASM #2 stated that she didn't see where the [MEDICATION(S)] was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the [MEDICATION(S)] has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy. On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of [MEDICATION(S)] on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, I don't remember why I signed that off. When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, No ma'am. When asked what why the [MEDICATION(S)] had not made it to the facility, LPN #2 stated, I don't know exactly the cause. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, Medication Shortage/Unavailable Medications documents in part, the following: Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified . 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. (1) [MEDICATION(S)]- [MEDICATION(S)] used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #211 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated [DATE]. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21. On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's [MEDICATION(S)] (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to her stomach and feeling itchy all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed [MEDICATION(S)]. Resident #211's care plan dated 6/24/21 documented the following for pain: Resident is at risk for pain related to [CONDITION(S)] (Stroke) with right [CONDITION(S)] .Administer analgesics/medications per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] Review of Resident #211's June, July and August 2021 POS (Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . This order was initiated on 6/24/21. Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that [MEDICATION(S)] was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m. Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of [MEDICATION(S)]. The first dose of [MEDICATION(S)] was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her [MEDICATION(S)] on 7/4/21 at 9:00 p.m; where it was documented she had (zero) capsules left. Review of the second narcotic sheet for [MEDICATION(S)] revealed that pharmacy had delivered 30 capsules of [MEDICATION(S)] on 7/9/21. Resident #211's first dose of [MEDICATION(S)] was on 7/9/21 at 2100 (9:00 p.m.). There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13 administrations). Review of the facility STAT Omnicell list revealed that [MEDICATION(S)] 100 mg was in the Omnicell STAT box. Further review of Resident #211's July 2021 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 2 p.m. and 9 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m. 7/8/21 at 6:00 a.m. and 9:00 p.m. and 7/9/21 at 6:00 a.m. The following administration note was documented on 7/5/21 at 7:51 p.m.: On hold until received per NP (Nurse Practitioner). The following note was documented on 7/6/21 by the Nurse Practitioner: .Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting) .Neuropathy: Continue [MEDICATION(S)] ([MEDICATION(S)]) 100 mg TID, script renewed. On 7/7/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg- Give 1 mg by mouth three times a day for pain .pharmacy to send. On 7/8/21 the following administration note was documented: [MEDICATION(S)] Capsule 100 mg .needs hard script. MD (medical doctor) aware. On 7/9/21 at 10:29 a.m., the following administration note was documented: [MEDICATION(S)] 100 mg three times a day for pain .per MD, administrator, DON (Director of Nursing) ok to give now. Further review of Resident #211's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] 7/5/21 at 6:00 a.m., 7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m., 7/8/21 at 2:00 p.m. On 8/4/21 at 2:45 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6, the nurse who worked the 11-7 shifts with Resident #211 and who did not administer her scheduled [MEDICATION(S)] at 6:00 a.m. When asked the process if she were to administer a narcotic and it was not available on the medication cart, LPN #6 stated that she would check to see if the medication was already ordered. LPN #6 stated that if the medication says its on order she would wait for the next shift to follow up as she is night shift. When asked what happened with Resident #211's [MEDICATION(S)], LPN #6 stated that she remembered the medication not being up from pharmacy for a couple of days. When asked what was going on with the [MEDICATION(S)], LPN #6 stated, No Idea. LPN #6 denied following up personally with the gapabentin to see why it had been missing for several days. LPN #6 denied Resident #211 having an increase in pain. She could not recall the resident complaining of nausea or an itchy feeling. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it was determined that the pharmacy did not receive a script for the [MEDICATION(S)] until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve [MEDICATION(S)] for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull [MEDICATION(S)] from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the [MEDICATION(S)] on the above dates. OSM #2 stated that the pharmacy initially sent out 28 capsules of [MEDICATION(S)] on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out [MEDICATION(S)] was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received [MEDICATION(S)] in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a.m. OSM #2 stated that the request to retrieve the [MEDICATION(S)] was made from the DON (Director of Nursing). When asked if there was any side effects or withdrawal effects to missing 12 doses of [MEDICATION(S)], OSM #2 stated that there was not necessarily any withdrawal effects, that missing that many doses would lead to pain returning back. OSM #2 stated that he would expect pain to return by the second missed dose. When asked if missing 12 administrations was considered a significant error, OSM #2 stated that he wouldn't say significant but that the resident would be uncomfortable. When asked if missing 12 doses could make someone who uses it for pain feel nauseous or itchy all over; OSM #2 stated that he could imagine it would make someone feel anxious which could lead to an upset stomach. OSM #2 was not familiar with [MEDICATION(S)] withdrawals causing an itchy feeling unless it was the really the pins and needles feeling. Further review of Resident #211's clinical record revealed no evidence of an increase in pain or a decrease in appetite during the time of her missed doses of [MEDICATION(S)]. The following; however was documented in a physical therapy note dated 7/8/21: Pt found supine in bed c/o (complaints) of not receiving her meds the last 3 days and says she is having withdrawal symptoms as she is itchy all over. PT attempts to consult nurse regarding this issue with PT unable to locate nurse. The next therapy note dated 7/9/21, documented in part, the following: Pt (Patient) found supine in bed, empathetic discussion had as pt reports she has not had her meds on the last 4 days. Nurse consulted regarding issue. Pt reports feeling itchy all over and nauseous. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the observation of 2 medication carts, 1 treatment cart and 1 medication room; the facility staff failed to dispose of expired medications and surgical supplies for two units. The facility staff failed to dispose of expired medications on Unit 1 and failed to discard two expired suture trays on unit 2. The findings include: On 3/17/21 at 11:09 AM an Inspection of Treatment Cart on Unit 2 was conducted with LPN (Licensed Practical Nurse) #4. Two suture removal Tray kits with an expiration date of 11/01/2020 was found during the inspection. LPN #4 replied, I should have discarded them. On 03/17/21 at 2:11 PM on unit 1 an inspection of medication cart #1 was conducted with LPN #3. Upon visual inspection a house stock bottle of acetaminophen 500 mg with an expiration date of 1/2021 was seen. It had an opened date of 3/08/21. Located in the same medication cart was 1 bottle of [MEDICATION(S)] insulin with an open date of 2/10/21. LPN #3 stated, I meant to take it out this morning. It's over twenty eight days. I should have discarded the insulin and Tylenol. Numerous attempts were made to obtain a policy/policies on expired medications and biologicals from the facility administrator. An exit interview was conducted on 3/18/21 at 2:28 PM with with the Regional Vice President of Operations (Corporate Staff #3) No comments were voiced.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - Few	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** Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for one of 36 residents in the survey sample, Resident #27. The findings included: 1. Resident #27 was admitted to the facility on [DATE]. diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #27's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 02/13/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #27 as requiring total dependence of one person with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing and supervision with setup help only for eating. On 03/17/2021 Resident #27's Clinical Record was reviewed and revealed the following: Review of Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . Order Date: 02/10/2021 Start Date: 02/10/2021. Review of Treatment Administration Record (TAR) for the period of 2/1/2021 - 2/28/2021 revealed the following dates with blank spaces: Day E 2/12, 2/13, 2/14, 2/15, 2/16, 2/20, 2/21, 2/23, 2/24, 2/25, 2/27/2021; Night 2/10, 2/13, 2/26. Review of Treatment Administration Record for the period of 3/1/2021 - 3/31/2021 revealed the following dates with blank spaces: Day E 3/2, 3/5, 3/10, 3/11, 3/13. On 03/18/2021 at approximately 9:30 a.m., an interview was conducted with the Unit Manager. When asked what do blank spaces indicate on the Treatment Administrative Records, Unit Manager stated, Either not signed out or hit Other. If the nurse does not sign out, initial, space will be blank. On 03/18/2021 at approximately 10:45 a.m., an interview was conducted with the Director of Nursing. The blank spaces on the Treatment Administrative Records for February 2021 and March 2021 were reviewed with the Director of Nursing. When asked if something should be documented in the blank spaces on the Treatment Administrative Records, Director of Nursing stated, Yes, if there is a blank and no key it makes me question. Can't answer for them or her. The Administrator, Director of Nursing and Regional Vice President of Operations were informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	03/18/2021

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, staff interviews and facility documentation the facility staff failed to have the required minimal committee members attend QAA meetings and failed to meet on a quarterly basis. The findings included: On 3/18/21 at approximately 11:16 AM, a review of the facilities QA/QAPI Plan was conducted and findings were discussed with the Administrator, DON (Director of Nursing), The Regional Director of Operations and The Regional Director of Clinical Services. A review of the QAPI Plan signature page revealed that the Medical Director/designee did not attend the required amount of meetings on the following meeting dates: 2/18/20, 5/21/20 and 5/28/20. The QAPI Plan also revealed that the required quarterly meetings were not conducted. The meetings were conducted on the following dates: 2/18/20, 5/21/20, 5/28/20, 11/30/20 and 2/26/21. No quarterly meetings were conducted in August 2020. (This should have been the 3rd quarterly meeting). The VP (Vice President) of Regional Operations stated, We purchased the nursing home in November 2020. Policy: Quality Assurance and Performance Improvement (QAPI) Program Policy. Effective: 11/28/17. Last Revision Date: 5/28/2020. QAPI efforts are a component of the facility QAA (Quality Assessment and Assurance) committee's responsibilities. The QAA Committee is responsible for both Quality Assessment and Assurance activities (QA) and ongoing, proactive, performance improvement (PI) activities. QAPI represents the merger of these two processes. The purpose of QAPI in the facility is to take a proactive approach to continually improving delivery of care and services and to engage residents, caregivers, and other clinical/operational partners in maximizing quality of life and quality of care. The facility will maintain a QAPI Committee consisting, at a minimum, of: (A) The administrator. (B) The Director of Nursing Services. (C) The Medical Director or his/her designee. (D) The designated Infection Preventionist. (E) Direct Care Staff on a rotating basis. (F)Staff from ancillary departments on a rotating basis. (G) At least two other members of the facility staff. The Committee will meet at least quarterly, and as needed, to coordinate and evaluate activities of the QAPI program/plan. This includes development and implementation of action plans to correct opportunities for improvement and regular review and analysis of data collected under QAPI program/plan. An exit interview was conducted on 3/18/21 at 2:28 PM with the Vice President of Regional Operations (Corporate Staff #3). No further comments were made.