STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (FAIR OAKS)	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/26/2022 through 9/28/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E000		
F000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted September 26, 2022 through September 28, 2022. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Eleven complaints were investigated during the survey, VA00052930 (unsubstantiated), VA00053608 (unsubstantiated), VA00055127 (unsubstantiated), VA00055868 (substantiated with deficiency), VA00053185 (substantiated with no deficiency), VA00053610 (unsubstantiated), VA00053323 (unsubstantiated), VA00053762 (substantiated with deficiency), VA00054259 (unsubstantiated), VA00052975 (substantiated with deficiency), VA00051970 (unsubstantiated). The census in this 155 bed certified facility was 124 at the time of the survey. The survey sample consisted of 33 current resident reviews and nine closed record review.	F000	**F000** **ProMedica Fair Oaks ("Center") is filing this Plan of Correction for the purposes of regulatory compliance. This Center is submitting this plan of correction to comply with applicable laws and not as an admission or statement of agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.**	
F578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F578		

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

Shurday Carter Electronically Signed Administrator 10/24/2022

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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F578	Continued From page 1 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) 483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. 483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly	F578	**F578** **1. Corrective Action** **Resident #70, resident #34, and resident #60 suffered no ill effects from this deficient practice and their advanced directives have been reviewed. Resident #71 is no longer a resident within the Center.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice. Current residents residing in the Center have had their records reviewed and, as found appropriate, their advanced directives were reviewed.** **3. New Measures or Systemic Change** **The Licensed Nursing Home Administrator re-educated the Center Social Workers on the importance of reviewing resident advanced directives and the regulation which addresses it.** **4. Monitoring** **The Administrator will audit random resident records to ensure advanced directives were reviewed with the resident and/or responsible party. Audits will be conducted weekly for four week and monthly for two months thereafter. The results of these audits will be reported monthly**	

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F578	Continued From page 2 at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review advance directives periodically with four of 42 residents in the survey sample, Residents #70, #71, #34 and #60. The findings include: 1. For Resident #70 (R70), the facility staff failed to review the advance directive since 10/13/2021. On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 8/16/2022, the resident scored a zero out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. The physician order dated 10/19/2021, documented, "DNR/DNT (do not resuscitate/do not transport)." The "Social Services Assessment and History" dated, 10/13/2021, documented in part, "Does the patient make his/her own decisions - no. Name of patient's decision maker - wife. Does the patient/patient's decision maker report that advance care planning has been completed - no. Does the patient/patient's decision maker want information on advance care planning - yes. Comments - Provided copy of the 5 wishes."	F578	**to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F578	Continued From page 3 The "Care Plan Progress Note," dated 10/19/2021, documented in part, "SW (social worker) reviewed code status, patient is a DNR, wife confirmed." On 9/27/2022 at 2:54 p.m. and interview was conducted with ASM (administrative staff member) #1, the administrator. When asked who is responsible for reviewing the advance directive with the resident and/or responsible party periodically, ASM #1 stated, social services. An interview was conducted with OSM (other staff member) #6, the social services coordinator and OSM #7, the social worker, on 9/27/2022 at 3:08 p.m. When asked who is responsible for reviewing the resident's advance directive with the resident and/or resident representative, OSM #7 stated it is their responsibility to review it quarterly and as needed. When asked what is included in an advance directive, OSM #7 stated it is the documentation of financial, power of attorney, and health care decisions for the resident. OSM #7 stated she likes to offer the resident a copy of the five wishes. When asked if you do it quarterly and as needed, where it is documented, OSM #6 stated if we do an assessment, there is a section to discuss that. It should be done in the care plan meeting also. When asked where the documentation of a review of R70's advance directive since 10/13/2021, OSM #7 stated she would like to check her documentation. OSM #7 stated it is probably a product of the fact that there has been turn over within the department. On 9/27/2022 at 3:42 p.m. OSM #6 and OSM #7 returned and stated they did a sweep of the record, there is no documentation for the periodic review. When asked if there should be	F578		

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F578	Continued From page 4 documentation, OSM #7 stated, yes. The comprehensive care plan dated, 5/31/2022, documented in part, "Focus: Pt DNR/DNT." The interventions documented in part, "Respect my code status advanced directives and/or choices in care. Respect code status will be reviewed quarterly and as needed." The facility policy, "Advance Care Planning: Code Status," documented in part, "Quarterly and with Changes in Condition: Review the patient's code status/advance care plan with quarterly care plans and changes in condition." ASM #1, and ASM #2, the director of nursing, were made aware of the above concern on 9/27/2022 at 4:52 p.m. No further information was provided prior to exit. 2. For Resident #71 (R71), the facility staff failed to evidence of a review of the resident's advance directive. On the most recent MDS assessment, an annual assessment, with an ARD of 8/18/2022, the resident scored a 13 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions. Review of the clinical record failed to evidence any documentation of discussion of an advance directive. The physician order dated, 5/11/2021 documented, "DNR (Do not resuscitate)." A physician order dated 7/7/2021 documented, "Do Not Hospitalize." The comprehensive care plan dated, 5/31/2022,	F578		

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F578	Continued From page 5 documented in part, "Focus: Resident desires to be DNR, DNT." The "Interventions" documented in part, "Honor and respect my code status and decision in my care. Review my code status and/or advance directives quarterly and as needed." On 927/2022 at 9:55 a.m. a request was made for the evidence of the discussion of an advance directive with R71 and/or their representative within the past 12 months. On 9/27/2022 at 2:54 p.m. ASM #1, the administrator, stated there is no evidence of an advance directive discussion for R71. When asked who is responsible for the discussion of an advance directive for the residents, ASM #1 stated, social services. An interview was conducted with OSM (other staff member) #6, the social services coordinator and OSM #7, the social worker, on 9/27/2022 at 3:08 p.m. When asked who is responsible for reviewing the resident's advance directive with the resident and/or resident representative, OSM #7 stated it is their responsibility to review it quarterly and as needed. When asked what is included in an advance directive, OSM #7 stated it is the documentation of financial, power of attorney, and health care decisions for the resident. OSM #7 stated she likes to offer the resident a copy of the five wishes. When asked if you do it quarterly and as needed, where it is documented, OSM #6 stated if we do an assessment, there is a section to discuss that. It should be done in the care plan meeting also. When asked where the documentation of a review of R71's advance directive, OSM #7 stated she would like to check her documentation. OSM #7 stated it is probably a product of the fact that there has been turn over	F578		

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F578	Continued From page 6 within the department. On 9/27/2022 at 3:42 p.m. OSM #6 and OSM #7 returned and stated they did a sweep of the record, there is no documentation for the periodic review. When asked if there should be documentation, OSM #7 stated, yes. ASM #1, and ASM #2, the director of nursing, were made aware of the above concern on 9/27/2022 at 4:52 p.m. No further information was provided prior to exit. 3. For Resident #34 (R34), the facility staff failed to review the advance directive since 1/18/2022. On the most recent MDS assessment, a quarterly assessment, with an ARD of 7/20/2022, the resident scored a 15 out of 15 on the BIMS score, indicating the resident is not cognitively impaired for making daily decisions. The physician order dated, 1/15/2022, documented in part, "Full Code (provide cardiopulmonary resuscitation if their heart stops or they stop breathing)." The "Social Services Assessment and History" dated, 1/18/2022, documented in part, "Does the patient make his/her own decisions - yes. Does the patient/patient's decision maker report that advance care planning has been completed - no. Does the patient/patient's decision maker want information on advance care planning - yes. Comments - Provided copy of the 5 wishes." The comprehensive care plan documented in part, "Focus: Resident: Full Code." The "Interventions" documented, "Respect and honor	F578		

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F578	Continued From page 7 resident choices in care. Review resident code status wishes quarterly or as needed." An interview was conducted with OSM (other staff member) #6, the social services coordinator and OSM #7, the social worker, on 9/27/2022 at 3:08 p.m. When asked who is responsible for reviewing the resident's advance directive with the resident and/or resident representative, OSM #7 stated it is their responsibility to review it quarterly and as needed. When asked what is included in an advance directive, OSM #7 stated it is the documentation of financial, power of attorney, and health care decisions for the resident. OSM #7 stated she likes to offer the resident a copy of the five wishes. When asked if you do it quarterly and as needed, where it is documented, OSM #6 stated if we do an assessment, there is a section to discuss that. It should be done in the care plan meeting also. When asked where the documentation of a review of R34's advance directive, OSM #7 stated she would like to check her documentation. OSM #7 stated it is probably a product of the fact that there has been turn over within the department. On 9/27/2022 at 3:42 p.m. OSM #6 and OSM #7 returned and stated they did a sweep of the record, there is no documentation for the periodic review. When asked if there should be documentation, OSM #7 stated, yes. ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 9/27/2022 at 4:52 p.m. No further information was provided prior to exit.	F578		

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F578	Continued From page 8 4. For Resident #60 (R60), the facility failed to provide evidence of a periodic review of the resident's advance directives. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/8/22, R22 was coded as being cognitively intact for making daily decisions, having scored 13 out of the on the BIMS (brief interview for mental status). A review of R60's clinical record failed to reveal any evidence of a periodic review of the resident's advance directive. On 9/27/22 at 3:07 p.m., OSM (other staff member) #6, Social Services Coordinator and OSM #7, social worker, were interviewed. OSM #7 stated it is the social workers' responsibility to review residents' advance directives quarterly and as needed. She stated advance directives include financial concerns, health concerns, and power of attorney concerns. She stated ordinarily, she completes a social services assessment quarterly, often during the care plan meeting. She stated this assessment contains a section addressing advance directives. When asked why the facility could not provide evidence of R60's advance directive reviews, OSM #7 stated there has been a great deal of staff turnover in the social services department. She stated some conversations with residents and families may not have been documented. However, she did not recall any conversations with R60 regarding advance directives. On 9/27/22 at 4:28 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.	F578		

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F578	Continued From page 9 No further information was provided prior to exit.	F578	**F580** **1. Corrective Action** **Resident #222 was discharged from the Center.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The Director of Nursing and/or unit managers and/or nursing supervisors will re-educate the licensed nursing staff on the importance of notifying the resident or the resident's responsible party of changes in physician orders and documenting such notification.** **4. Monitoring** **The Director of Nursing and/or unit managers and/or nursing supervisors will audit random resident records with new physician orders to verify that the resident or the resident's responsible party was notified of changes in medication weekly for four weeks and monthly for two months thereafter. The results of these audits will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	
F580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) 483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in 483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in 483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in 483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F580		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (FAIR OAKS)	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F580	Continued From page 10 representative(s). 483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in 483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under 483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to notify a resident's representative (RR) of a need to alter treatment for one of 42 residents in the survey sample, Resident #222. The findings include: For Resident #222 (R222) the facility staff failed to notify the RR when the medication ferrous sulfate (iron) was discontinued on 8/25/21 and a new medication calcitriol (1) was initiated on 1/19/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/24/22, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. A review of R222's clinical record revealed a nurse practitioner's note dated 8/25/22 that documented, "Pt (Patient) has CKD (chronic kidney disease) stage IV w (with) chronic onset.	F580		

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	495217	A. BUILDING _____ B. WING _____	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (FAIR OAKS)	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F580	Continued From page 11 Condition is exacerbated by history of type 2 diabetes, frequent urinary tract infections, poor PO (by mouth) intake of water despite encouraging water, and dementia. Last visit pt was complaining of malaise, and labs was done...Pt being seen today to evaluate for hemodynamic stability/volume status to avoid adverse events including but not limited to cardiac complications, organ failure, coma and death... D/C (Discontinue) ferrous sulfate daily..." R222's ferrous sulfate 325 mg (milligrams) by mouth once a day (ordered on 7/9/21) was discontinued on 8/25/21. Further review of R222's clinical record, including progress notes, failed to reveal evidence that R222's RR was notified and made aware the ferrous sulfate was discontinued. A note signed by the nephrologist on 1/19/22 documented, "Seen in nephrology clinic; started calcitriol..." A review of R222's physician's order summary revealed a physician's order dated 1/19/22 for calcitriol 0.25 mcg (micrograms) by mouth every other day for supplement. Further review of R222's clinical record, including progress notes, failed to reveal evidence that R222's RR was notified and made aware of the new order for calcitriol. On 9/27/22 at 2:44 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated a resident's [RR] should be notified when a new medication is initiated or when a medication is discontinued. LPN #5 stated nurses evidence notification by documenting a progress note. On 9/27/22 at 4:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F580		

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F580	Continued From page 12 The facility policy titled, "Change of Condition Protocol-Resident Services" documented, "Determine whether the responsible party needs to be notified of the situation at this time." The policy did not document specific information regarding RR notification of the initiation or discontinuation of medications. No further information was presented prior to exit. Reference: (1) Calcitriol is used to treat and prevent low levels of calcium and bone disease in patients whose kidneys are not working normally. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682335.html	F580		
F641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) 483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility staff failed to complete an accurate MDS (minimum data set) for three of 42 residents in the survey sample, Residents #120, #88, and #26. The findings include: 1. For Resident #120 (R120), the facility staff failed to accurately code the significant change	F641	**F641** **1. Corrective Action** **Resident #120, #88, and #26 suffered no ill effects from this deficient practice.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The Regional Clinical Reimbursement Specialist will re-educate MDS Coordinators and Social Workers on the importance of accurate MDS coding/not dashing**	

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F641	Continued From page 13 MDS with an ARD (assessment reference date) of 9/13/22 for the resident's cognitive status. On the most recent MDS, a significant change assessment with and ARD of 9/13/22, R120 was not coded for cognitive status or for results of the resident's BIMS (brief interview for mental status). Each box in Section C (BIMS) of the MDS contained a dash. On 9/27/22 at 1:15 p.m., RN (registered nurse) #3, the MDS coordinator, was interviewed. She stated the social workers are ordinarily responsible for completing Section C (BIMS scoring) of the MDS. On 9/27/22 at 1:49 p.m., OSM (other staff member) #6, Social Services Coordinator, and OSM #7, social worker, were interviewed. OSM #7 stated RN #3 had completed section C for R120's 9/13/22 MDS. She stated: "Section C should never be 'dashed.'" When asked what "dashed" means, she stated: "Not assessed." When asked if the MDS of a current resident should ever have dashes instead of numbers in Section C, she stated: "No. Not ever. You should always assess a resident's cognition." On 9/27/22 at 2:12 p.m., RN #3 was interviewed again. When shown section C of R120's 9/13/22 MDS, she stated: "The social workers normally get those areas." She stated there are ordinarily two social workers completing MDSs. If one social worker is not working when an MDS is due, the other social worker picks it up. She stated: "If we aren't told a social worker has missed a section, we can't complete it." She stated she marked Section C as "not assessed" with a dash because it was the only honest response. She added: "We have been really short of social workers." She stated this MDS is	F641	**and the importance of notifying the Administrator of any department that fails to complete their assigned section of the MDS by the required date.** **4. Monitoring** **The Administrator will audit random MDS assessments to ensure MDS accuracy and completion weekly for four weeks and monthly for two months thereafter. The results of these audits will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F641	Continued From page 14 not accurate. She stated the RAI (resident assessment instrument) manual is the facility's resource for completing an accurate MDS. On 9/27/22 at 4:28 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1 October 2019 revealed, in part, the following: "SECTION C: COGNITIVE PATTERNS Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions...A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. - Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care...Coding Instructions: o Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status...Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words...Coding Tips o Attempt to conduct the interview with ALL residents. This interview is conducted during the	F641		

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F641	Continued From page 15 look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood....If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items." No further information was provided prior to exit. 2. For Resident #88 (R88), the facility staff failed to accurately code the quarterly MDS with an ARD (assessment reference date) of 8/23/22 for the resident's cognitive status. On the most recent MDS, a quarterly assessment with and ARD of 8/23/22, R88 was not coded for cognitive status or for results of the resident's BIMS (brief interview for mental status). Each box in Section C (BIMS) of the MDS contained a dash. On 9/27/22 at 1:15 p.m., RN (registered nurse) #3, the MDS coordinator, was interviewed. She stated the social workers are ordinarily responsible for completing Section C (BIMS scoring) of the MDS. On 9/27/22 at 1:49 p.m., OSM (other staff member) #6, Social Services Coordinator, and OSM #7, social worker, were interviewed. OSM #7 stated a contract nurse who no longer works at the facility had completed section C for R88's 8/23/22 MDS. She stated: "Section C should never be 'dashed.'" When asked what "dashed" means, she stated: "Not assessed." When asked if the MDS of a current resident should ever have dashes instead of numbers in Section C, she stated: "No. Not ever. You should always	F641		

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F641	Continued From page 16 assess a resident's cognition." On 9/27/22 at 2:12 p.m., RN #3 was interviewed again. When shown section C of R88's 8/23/22 MDS, she stated: "The social workers normally get those areas." She stated there are ordinarily two social workers completing MDSs. If one social worker is not working when an MDS is due, the other social worker picks it up. She stated: "If we aren't told a social worker has missed a section, we can't complete it." She stated she marked Section C as "not assessed" with a dash because it was the only honest response. She added: "We have been really short of social workers." She stated she does not specifically remember which assessments the contract MDS nurse was assigned. She stated this MDS is not accurate. She stated the RAI (resident assessment instrument) manual is the facility's resource for completing an accurate MDS. On 9/27/22 at 4:28 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. 3. For Resident #26, (R26), the facility staff failed to accurately code the quarterly MDS with an ARD (assessment reference date) of 7/13/22 for the resident's cognitive status. On the most recent MDS, a quarterly assessment with and ARD of 7/13/22, R26 was not coded for cognitive status or for results of the resident's BIMS (brief interview for mental status). Each box in Section C (BIMS) of the MDS contained a dash.	F641		

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F641	Continued From page 17 On 9/27/22 at 1:15 p.m., RN (registered nurse) #3, the MDS coordinator, was interviewed. She stated the social workers are ordinarily responsible for completing Section C (BIMS scoring) of the MDS. On 9/27/22 at 1:49 p.m., OSM (other staff member) #6, Social Services Coordinator, and OSM #7, social worker, were interviewed. OSM #7 stated RN #3 had completed section C for R26's 7/13/22 MDS. She stated: "Section C should never be 'dashed.'" When asked what "dashed" means, she stated: "Not assessed." When asked if the MDS of a current resident should ever have dashes instead of numbers in Section C, she stated: "No. Not ever. You should always assess a resident's cognition." On 9/27/22 at 2:12 p.m., RN #3 was interviewed again. When shown section C of R26's 7/13/22 MDS, she stated: "The social workers normally get those areas." She stated there are ordinarily two social workers completing MDSs. If one social worker is not working when an MDS is due, the other social worker picks it up. She stated: "If we aren't told a social worker has missed a section, we can't complete it." She stated she marked Section C as "not assessed" with a dash because it was the only honest response. She added: "We have been really short of social workers." She stated this MDS is not accurate. She stated the RAI (resident assessment instrument) manual is the facility's resource for completing an accurate MDS. On 9/27/22 at 4:28 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.	F641		

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F641	Continued From page 18 No further information was provided prior to exit.	F641	**F676**	
F676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) 483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: 483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... 483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: 483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, 483.24(b)(2) Mobility-transfer and ambulation, including walking, 483.24(b)(3) Elimination-toileting, 483.24(b)(4) Dining-eating, including meals and snacks, 483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.	F676	**1. Corrective Action** **Resident #424 was discharged from the facility on March 29, 2021 and was not harmed by this deficient practice.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The Director of Nursing, unit managers and/or nursing supervisors will re-educate the certified nursing aids (CNAs) on the importance of ensuring ADL care is given and documented.** **4. Monitoring** **The Director of Nursing and/or unit managers and/or nursing supervisors will conduct random audits to ensure ADL care was performed and documented. The audits will be conducted weekly for four week and monthly for two months thereafter. The results of these audits will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F676	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to provide evidence of ADL (activities of daily living) care for one of 42 residents, Resident #424. The findings include: The facility staff failed to evidence that personal hygiene, specifically showers and/or bed baths was provided to Resident #424. Resident #424 was admitted to the facility on 3/22/21 with diagnosis that included but were not limited to: dementia, and acute pulmonary embolism. Resident #424 was discharged home on 3/29/21. The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 3/29/21, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not able to complete the interview. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfers, dressing, hygiene, bathing and eating; requiring limited assistance for ambulation and locomotion. A review of the comprehensive care plan dated 3/22/21 revealed, "FOCUS: ADL Self-care deficit related to physical limitations. INTERVENTIONS: Assist to bathe/shower as needed. Assist with daily hygiene, grooming,	F676		

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F676	Continued From page 20 dressing, oral care and eating as needed." A review of Resident #424's ADL (activities of daily living) records from 3/22/21-3/29/21, revealed: SHOWER/BATH: Wednesday Days (shift) on 3/24/21 "RR" was documented in box. SHOWER/BATH: Saturday Days (shift) on 3/27/21 "BB 2" was documented in the box . The CNA (certified nursing assistant) whose initials were in the documentation blocks for 3/24/21 and 3/27/21 was no longer employed at the facility. An interview was conducted on 9/28/22 at 7:45 AM, with a current employee, CNA #8. When asked where bathing would be documented outside of the designated two shower/bath days per week, CNA #8 stated, there was no way to mark it in the computer. CNA #8 stated, "This resident was assigned shower days two days out of the week, on Wednesday and on Saturday. We do not have any other place to document if a patient is given a bed bath or washed between shower days." When asked what RR means, CNA #8 stated, it means that the resident refused. CNA #8 pulled up ADL sheet at the nurse's station with her logon and stated, you see, there is no place to document any additional care given, than what the computer brings up. When asked if there are any places to document notes, CNA #8 stated, there is an alert we can do, but we do not use it for this. An interview was conducted on 9/28/22 at 8:15 AM, with CNA #9. When asked what bathing routine is followed for residents, CNA #9 stated, they are scheduled for twice a week showers or baths. If the resident wants multiple showers or bed baths per week, we give them to them. When asked where that is documented, CNA #9	F676		

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PROMEDICA SKILLED NURSING AND REHAB (FAIR OAKS)	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F676	Continued From page 21 stated, we can document it in the CNA form. There are "x's" in the form except for the two designated shower/bath days. When asked if you can override the x, CNA #9 stated, "Not that I know of." An interview was conducted on 9/28/22 at 9:00 AM, with ASM (administrative staff member) #2, the director of nursing. When asked where the CNAs can document additional showers or bed baths for the residents above the two per week, ASM #2 stated, they would document it under alert charting, for additional care provided and it would show on the ADL report. When asked if there is no additional bathing documentation outside of the designated two shower/bath days per week what does that mean? ASM #2 stated, if it does not show on the ADL report, there is no evidence that the care was provided. On 9/28/22 at 12:30 PM, ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the concerns. A review of the facility's "Bathing" policy, dated 7/16, revealed, "Purpose to cleanse the skin and promote circulation. Document in PCC (point click care): care provided and any unusual observations and, or complaints and subsequent interventions including communications with physicians as clinically indicated." A review of the facility's "Personal Care and Activities of Daily Living" policy, dated 6/21, revealed, "The community goal is to maintain the resident's routine with personal care and activities of daily living, as specified in the service plan. Procedure: Personal care services include: assisting with bathing." No further information was provided prior to exit.	F676		

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F676	Continued From page 22 Complaint deficiency.	F676		
F684 SS=D	Quality of Care CFR(s): 483.25 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to follow the physician's order for medication administration one of 42 residents in the survey sample, Resident #372 (R372). The findings include: The facility staff failed to administer Ambien (1) as ordered to R372 on 11/10/2021 at 9:00 p.m., which was available in the facility's automated medication dispensing system. On the most recent MDS (minimum data set), a five-day admission assessment with an ARD (assessment reference date) of 11/13/2021, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.	F684	**F684** **1. Corrective Action** **Resident #372 was discharged from the facility on November 13, 2021 and was not harmed by this deficient practice.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The nurse responsible for not administering the medication (Ambien) per physician orders was re-educated on the facility policy for administering medications per physician orders and the process in place to obtain medications from the Center's automated medication system as necessary.** **All licensed nursing staff will be re-educated on the facility policy administering medications per physician orders and the process in place to obtain medications from the Center's automated medication system.** **4. Monitoring** **The Director of Nursing and/or unit managers and/or nursing supervisors will audit random newly admitted**	

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F684	Continued From page 23 The physician orders for R372 documented in part, "Ambien Tablet 10 MG (milligram) (Zolpidem Tartrate) Give 2 (two) tablet by mouth at bedtime for Insomnia. Order Date: 11/9/2021. Start Date: 11/9/2021." The eMAR (electronic medication administration record) for R372 dated 11/1/2021-11/30/2021 was reviewed and revealed in part, "Ambien Tablet 10 MG (Zolpidem Tartrate) Give 2 tablet by mouth at bedtime for Insomnia." The Ambien was scheduled to be administered each night at 9:00 p.m. starting on 11/9/2021. It was documented that R372 received the Ambien on 11/9/2021 however the Ambien was not documented as administered on 11/10/2021. The eMAR revealed a "9" in the administration documentation area for the Ambien on 11/10/2021 at 9:00 p.m. The eMAR chart codes documented in part, "9=Other / See Nurse Notes." The progress notes for R372 documented in part, - "11/9/2021 19:29 (7:29 p.m.) General progress note. Patient arrived in facility this evening from [Name of hospital] via stretcher escorted by EMS (emergency medical services) and daughter...Medications were reconciled or reviewed by the MD (medical doctor) with no issues noted, and were processed with pharmacy for delivery..." - "11/10/2021 20:50 (8:50 p.m.) Ambien Tablet 10 MG, Give 2 tablet by mouth at bedtime for Insomnia. On process from pharmacy." The facility provided list of medications available in the stat box and automated medication system documented Ambien 10 mg and Ambien 5 mg tablets available to remove for residents	F684	**resident medication administration records to ensure all medications were delivered per physician orders. The audits will be conducted weekly for four week and monthly for two months thereafter. The results of these audits will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F684	Continued From page 24 with approval from pharmacy. On 9/27/2022 at 11:44 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated that they worked as supervisor and did not remember R372. RN #4 stated that when residents were admitted from the hospital they arrived with a list of medications. RN #4 stated that they reviewed the medication list with the physician on admission and entered the medication orders into the computer for the pharmacy to fill the order for medications. RN #4 stated that medications entered before 5:00 p.m. were received around 1:00 a.m. that night and orders entered after 5:00 p.m. were received the next day. RN #4 stated that any medications needed the same day for the resident were put in as "stat" (now) and were sent by the pharmacy on their next delivery. RN #4 stated that they also had an automated medication system which stored stock medications that they could pull from after the pharmacy approved orders and gave them an access code. RN #4 stated that they normally had a newly admitted residents medications delivered from the pharmacy by the next day. On 9/27/2022 at 4:58 p.m., an interview was conducted with RN #5. RN #5 stated that medications for newly admitted residents were entered into the computer for the pharmacy to fill. RN #5 stated that if the medications were not available when ordered to be administered they were to check with the pharmacy to make sure the physician had sent the prescription over. RN #5 reviewed the eMAR for R372 dated 11/10/2021 for Ambien scheduled at 9:00 p.m. and stated that it appeared the medication was on order from the pharmacy and not given. RN #5 stated that they did not remember R372 or the medication not being available on that date	F684		

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F684	Continued From page 25 and could only go by the note that was written. RN #5 stated that they had an automated medication system which stored Ambien in it and would be able to remove medication from it with an authorization code from the pharmacy. RN #5 stated that they could not say whether or not there was Ambien in the machine that day or not. RN #5 stated that when a medication was not administered as ordered they were to notify the responsible party, the physician and called the pharmacy. RN #5 stated that this should be documented in the nurses notes. On 9/28/2022 at 8:51 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that on admission the nurses verified the medications with the physician, entered the medications into the computer and printed out a summary for the physician to sign and verify. ASM #2 stated that the automated medication system was stocked with a months supply of medication for staff to pull from. ASM #2 stated that they did not remember R372 however if they were admitted with an order for Ambien the nurses would have faxed the order to the pharmacy and the pharmacy would have given them a code to allow them to pull the medication from the automated medication system until it was filled for the resident. The facility policy "Standard Operating Procedure: Automated Dispensing Devices located in licensed Nursing Homes-Accessing Medications" dated 12/10/2020, documented in part, "Purpose: Medications will be removed from the automated dispensing unit per a physician's order and for one patient at a time...1. The nurse will utilize the patient's MAR (medication administration record), the official record of active medications, to identify	F684		

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F684	Continued From page 26 medications needed from the automated dispensing system..." On 9/28/2022 at approximately 12:30 p.m., ASM #1, the administrator, ASM #2, the director of nursing and LPN (licensed practical nurse) #5, were made aware of the findings. No further information was provided prior to exit. Complaint deficiency. Reference: (1) Ambien Ambien is a sedative, also called a hypnotic. Zolpidem affects chemicals in the brain that may be unbalanced in people with sleep problems insomnia). This information was obtained from the website: https://www.drugs.com/ambien.html	F684		
F689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) 483.25(d) Accidents. The facility must ensure that - 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and 483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to maintain a safe environment for one of 42 residents in the survey sample,	F689	**F689** **1. Corrective Action** **Resident #42 was not harmed by this deficient practice.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The Director of Nursing, unit managers and/or nursing supervisors will re-educate the licensed nursing staff on the importance of not leaving any medication at the bedside of a resident.**	

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F689	Continued From page 27 Resident #42. The facility staff failed to ensure Resident #42 (R42) did not have access to Greer's goo (1) a compound medicated cream containing medication that R42 was allergic to. The findings include: On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/25/22, the resident's cognitive skills for daily decision making were coded as severely impaired. On 9/26/22 at 12:20 p.m., R42 was observed sitting on a walker in the bedroom. On 9/26/22 at 1:26 p.m., R42 was observed sitting in the bedroom and eating. During both observations, a plastic jar of Greer's goo (containing zinc oxide, hydrocortisone and nystatin) was observed on R42's nightstand. The jar was labeled with another resident's name and was three fourths full. A review of R42's clinical record failed to reveal an assessment for medication self-administration, failed to reveal a physician's order for Greer's goo and revealed R42 was allergic to hydrocortisone. R42's comprehensive care plan dated 3/24/14 documented, "At risk for complications r/t (related to) allergy to Hydrocortisone..." (Note: observation of R42 failed to reveal symptoms of an allergic reaction and a review of nurses' notes for 9/21/22 through 9/27/22 failed to reveal documentation regarding an allergic reaction). On 9/27/22 at 2:44 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated Greer's goo should be kept	F689	**4. Monitoring** **The Director of Nursing and/or unit managers and/or nursing supervisors will perform random room rounds to ensure no medication is at the resident's bedside weekly for four week and monthly for two months thereafter. The results of these rounds will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F689	Continued From page 28 locked in a treatment cart because it is a medication. LPN #5 stated Greer's goo should not be left unattended in a resident's room unless there is an assessment that deems it is appropriate to leave the medication at the bedside and there is a physician's order to keep the medication at the bedside. LPN #5 stated R42 did not have an assessment for medication self-administration. LPN #5 was made aware of the above observations and could not explain why another resident's Greer's goo was unattended in R42's room. On 9/27/22 at 4:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "STORAGE AND EXPIRATION DATING OF DRUGS, BIOLOGICALS, SYRINGES AND NEEDLES" documented, "The Nursing Center should ensure that all drugs and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room, inaccessible by residents and visitors." No further information was presented prior to exit. Reference: (1) "In 1971 dermatologist Kenneth Greer found the Greer's goo formula in an old textbook and popularized it after successfully treating his daughter's diaper dermatitis. The classic version consists of nystatin powder (4 million units), hydrocortisone powder (1.2 grams, which equates to slightly less than 1%), and zinc oxide paste (4 ounces)." This information was obtained from the website: https://www.jaad.	F689		

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F689	Continued From page 29 org/article/S0190-9622 (17)31668-7/fulltext	F689		
F812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) 483.60(i) Food safety requirements. The facility must - 483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner in one of one facility kitchens and in three of three nourishment rooms. 1. The facility staff failed to close a box containing a bag of diced carrots, exposing them to the environment, in one of one walk-in freezers.	F812	**F812** **1. Corrective Action** **No residents were harmed by this deficient practice. The carrots in the walk-in freezer were discarded. All food items unlabeled and undated in the unit refrigerators was discarded.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The Director of Dietary Services will re-educate dietary staff on the importance of maintaining all foods in the kitchen in a safe sanitary manner. The Housekeeping Director will re-educate all housekeeping staff on the importance of maintaining all foods in the unit refrigerator in a safe sanitary manner.** **The Director of Nursing and/or unit managers and/or nursing supervisors will re-educate the nursing staff on the importance of maintaining all foods placed in the unit refrigerators in a sanitary manner.** **4. Monitoring** **The Director of Dietary Service will conduct random visual inspections of the kitchen freezer to ensure food is**	

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F812	Continued From page 30 2. The facility staff failed to label and date food available for use, found in the first floor, PARC unit and second floor nourishment room refrigerators in three of three nourishment room refrigerators. The findings include: 1. The facility staff failed to close a box containing a bag of diced carrots, exposing them to the environment, in one of one walk-in freezers. On 09/26/2022 at approximately 10:45 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #1, dietary manager. At approximately 10:58 a.m., an observation of the inside of the facility's walk-in freezer revealed a 30 pound box of diced carrots sitting on a shelf. Observation of the box revealed the diced carrots were in a plastic bag and further observation revealed the plastic was open, exposing the carrots to the environment. When asked how much of the diced carrots were remaining in the package, OSM #1 stated that there was approximately two-thirds of the product remaining. On 09/27/2022 at approximately 9:55 a.m., an interview was conducted with OSM #1, dietary manager. When asked to describe the procedure for storing food after it was opened, OSM # 1 stated that after an item is opened the package should be closed and dated when it was open. When asked why it was important to closed opened food items OSM #1 stated that it prevents exposure to the air, keeps it fresh and prevents freezer burn.	F812	**maintained in a sanitary manner weekly for four week and monthly for two months thereafter. The results of these inspections will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **The Housekeeping Director will visually inspect the three-unit refrigerators to ensure the food within the refrigerator is being maintained in a sanitary manner weekly for four week and monthly for two months thereafter.** **The Director of Nursing and/or unit managers and/or nursing supervisors will visually inspect the three-unit refrigerators to ensure the food within the refrigerator is being maintained in a sanitary manner weekly for four week and monthly for two months thereafter. The results of these inspections will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F812	Continued From page 31 The facility's policy "Storage of Food" documented in part, "14. Seal and label open frozen foods." On 09/27/2022 at approximately 4:30 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. 2. The facility staff failed to label and date food available for use, found in the first floor, PARC unit and second floor nourishment room refrigerators in three of three nourishment room refrigerators. On 09/26/2022 at approximately 3:10 p.m., an observation of the contents in the refrigerator in the first floor nourishment room was conducted with LPN (licensed practical nurse) #1. When asked to describe the procedure for the use of the unit refrigerator/freezers LPN #1 stated that they were used for the resident's food and that their name, the resident's room number should be on the items and the date when it was put in the refrigerator or freezer. When asked who was responsible for checking them and how often it was done LPN #1 stated that they did not know. Observation of the inside of the refrigerator revealed two soft sided lunch bags containing several food items, a zip lock plastic sandwich bags containing watermelon chunks and a "Sippy cup" with a white substance inside. Further observation of the items failed to evidence a resident's name, date or room number. When asked if they could identify the substance inside the sippy cup LPN #1 stated no.	F812		

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F812	Continued From page 32 On 09/26/2022 at approximately 3:18 p.m., an interview was conducted with OSM #1, dietary manager. When asked who was responsible for checking the refrigerators in the nourishment rooms OSM # 1 stated that it was housekeeping's responsibility. On 09/26/2022 at approximately 3:20 p.m., an observation of the contents in the refrigerator in the PARC unit nourishment room was conducted with LPN #2. When asked to describe the procedure for the use of the unit refrigerator/freezers LPN #2 stated that they were used for the resident's food and that their name, the resident's room number should be on the items and the date when it was put in the refrigerator or freezer. Observation of the inside of the refrigerator revealed a soft sided lunch bag containing several food items, a plastic bag containing a take-out container from a fast food restaurant containing food and a small container of mash potatoes and gravy. Observation of the freezer, above the refrigerator revealed nine chocolate bars. Further observations of the food items failed to evidence a resident's name, date or resident room number. On 09/26/2022 at approximately 3:30 p.m., an observation of the contents in the refrigerator in the second floor nourishment room was conducted with CNA (certified nursing assistant) #1. When asked to describe the procedure for the use of the unit refrigerator/freezers CNA #1 stated that they were used for the resident's food and that their name, the resident's room number should be on the items and the date when it was put in the refrigerator or freezer. Observation of the inside of the refrigerator revealed a 30 ounce bottle of mayonnaise. Observation of the freezer, above the refrigerator revealed a seven ounce frozen pot pie. Further observations of	F812		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F812	Continued From page 33 the food items failed to evidence a resident's name, date or resident room number. On 09/27/2022 at approximately 9:19 a.m., an interview was conducted with OSM #2, housekeeping director. When asked who was responsible for checking the refrigerators in the nourishment rooms OSM #2 stated that it was the housekeeping department and that they were checked every morning. When asked to describe the procedure for the use of the unit refrigerator/freezers OSM #2 stated that they were used for the resident's food and that their name, the resident's room number should be on the items and the date when it was put in the refrigerator or freezer. OSM #2 was then informed of the above observations of the facility's nourishment rooms. The facility's policy "Food From Outside Sources And In-Room Refrigerators" documented in part, "2. Foods, requiring refrigeration and non-perishable items are stored in labeled (with patient name and date of visit), closed containers supplied by the family or guest." On 09/27/2022 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F812		
F840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) 483.70(g) Use of outside resources. 483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by	F840	**F840** **1. Corrective Action** **Resident #42 suffered ill no effects from this deficient practice. Resident #42's dialysis provider entered into contract with the Center on October 7, 2022.**	

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F840	Continued From page 34 a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. 483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to evidence a current dialysis contract between the facility and the outpatient dialysis center providing services for one of 42 residents in the survey sample, Resident #30. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/15/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of Resident #30's (R30) clinical record revealed a physician's order dated 2/16/22 for hemodialysis at (name of company) every Tuesday, Thursday and Saturday. A review of the facility dialysis contracts failed to reveal a contract for R30's dialysis provider.	F840	**2. Other Potential Residents** **All other current residents receiving dialysis have a contract in place.** **3. New Measures or Systemic Change** **The Director of Nursing and/or unit managers and/or nursing supervisors will make it known to the Administrator during the morning stand up meeting of any newly admitted resident receiving dialysis.** **4. Monitoring** **The Administrator and/or the Director of Nursing will be responsible for reviewing the contract book to ensure there is a current contract with the dialysis center for any new admission receiving dialysis. Resident's receiving dialysis and contract status will be added to the monthly QAPI meetings for formal monitoring going forward.** **5. Completion Date** **November 9, 2022**	

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F840	Continued From page 35 On 9/27/22 at 12:27 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated she did not have a contract for R30's dialysis provider but she had a call out to the administrator at the provider. ASM #1 stated that ultimately it is her responsibility to ensure the facility has contracts with dialysis providers. ASM #1 stated there is not a system in place to ensure the facility has contracts with all dialysis providers for their residents and that is something that needs to be done. On 9/27/22 at 4:48 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. On 9/28/22 at 2:30 p.m., ASM #1 stated the facility did not have a policy regarding dialysis contracts. No further information was provided prior to exit.	F840		
F842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. 483.70(i) Medical records. 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F842	**F842** **1. Corrective Action** **Residents #47, #222, #121, #34, and #118 were not harmed by this deficient practice.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The Director of Nursing has educated the wound care consultants on the potential adverse effects of not having**	

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F842	Continued From page 38 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized 483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. 483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. 483.70(i)(5) The medical record must contain-	F842	**immediate access to their documentation. The wound care consultants have agreed to document, and place said documentation in the individual resident's record prior to leaving the Center on the date of the resident visit.** **4. Monitoring** **The Director of Nursing and/or unit managers and/or nursing supervisors will audit random records for residents seen by the wound care consultants to ensure compliance with placing documentation in the resident records prior to leaving the Center. The audits will be conducted weekly for four week and monthly for two months thereafter. The results of these audits will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F842	Continued From page 37 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under 483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to maintain a complete clinical record for five of 42 residents in the survey sample, Residents #47, #222, #121, #34 and #118. The findings include: 1. For Resident #47 (R47), the facility staff failed to maintain wound physician/nurse practitioner notes on the resident's clinical record. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/30/22, the resident scored 7 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. A review of R47's clinical record revealed a nurse's note dated 8/9/22 that documented, "Resident seen for skin assessment by this writer and the wound MD (medical doctor). The findings are as follows. 1. Sacral fissure measuring 3.0cmx3.0cmx0.3cm..." Further review of R47's paper and electronic clinical	F842		

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F842	Continued From page 38 record failed to reveal wound physician/nurse practitioner notes. On 9/27/22 at 2:17 p.m., LPN (licensed practical nurse) #5 presented wound physician/nurse practitioner notes for R47 that were dated 8/2/22, 8/9/22, 8/16/22, 8/30/22, 9/6/22, 9/13/22 and 9/20/22. LPN #5 stated she had to pull the notes from the wound physician's computer software portal. On 9/27/22 at 4:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 9/28/22 at 8:43 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated LPN (licensed practical nurse) #5 is the only employee who has access to the wound physician's computer software portal. ASM #2 stated the wound physician used to send his notes to the facility but hasn't been sending them since he changed the computer software a few months ago. ASM #2 stated wound physician/nurse practitioner notes absolutely should be in the clinical record. No further information was presented prior to exit. 2. For Resident #222 (R222), the facility staff failed to maintain wound physician/nurse practitioner notes on the resident's clinical record. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/24/22, the resident scored 3 out of 15 on the BIMS (brief interview for mental	F842		

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F842	Continued From page 39 status), indicating the resident was severely cognitively impaired for making daily decisions. A review of R222's clinical record revealed a nurse's note dated 9/7/21 that documented, "Resident seen for wound rounds by this writer and the wound MD (medical doctor). The findings are s (sic) follows. 1. Sacral fissure measuring 0.5cmx0.3cmx0.1cm..." Further review of R222's paper and electronic clinical record failed to reveal wound physician/nurse practitioner notes. On 9/27/22 at 4:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 9/28/22 at 7:47 a.m., ASM #1 presented wound physician/nurse practitioner notes for R222 that were dated 7/13/21, 8/17/21, 8/24/21, 8/31/21 and 9/7/21. On 9/28/22 at 8:43 a.m., an interview was conducted with ASM #2. ASM #2 stated R222's wound physician/nurse practitioner notes were not in the resident's clinical record. ASM #2 stated LPN (licensed practical nurse) #5 is the only employee who has access to the wound physician's computer software portal. ASM #2 stated the wound physician used to send his notes to the facility but hasn't been sending them since he changed the computer software a few months ago. ASM #2 stated wound physician/nurse practitioner notes absolutely should be in the clinical record. ASM #2 stated she could not explain why R222's 2021 notes were not in the clinical record. The facility policy titled, "Documentation" documented, "Clinical records are maintained on	F842		

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F842	Continued From page 40 each patient that are complete, readily accessible and systematically organized." No further information was presented prior to exit. 3. The facility staff failed to maintain wound care physician notes in the clinical record for Resident #121 (R121). On the most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 9/15/2022, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having one unstageable pressure injury. The facility provided a list of residents with pressure injuries (1) on 9/26/2022. R121 was documented on the list for having an unstageable pressure injury (2) on their sacrum. The physician order dated, 9/9/2022, documented in part, "Cleanse sacrum with NSS (normal saline solution), pat dry, apply calcium alginate to wound bed and cover with foam, every day shift for wound care." Review of the clinical record failed to evidence documentation from the wound care physician. A request was made on 9/27/2022 at 2:50 p.m. for the wound care documentation of wound measurements and documentation. A second request was made on 9/27/2022 at 4:52 p.m. for the wound care documentation.	F842		

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F842	Continued From page 41 The wound care physician notes were received on 9/28/2022 at approximately 8:00 a.m. The wound care physician notes were dated 9/13/2022 through 9/28/2022. On 9/28/22 at 8:43 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked where the notes came from, ASM #2 stated they came from the wound physician's portal. When asked if there were in the paper or electronic record, ASM #2 stated, no. ASM #2 stated LPN (licensed practical nurse) #5 is the only employee who has access to the wound physician's computer software portal. ASM #2 stated the wound physician used to send his notes to the facility but hasn't been sending them since he changed computer software a few months ago. ASM #2 stated wound physician/nurse practitioner notes absolutely should be in the clinical record. ASM #1, the administrator, ASM #2, and LPN #5, were made aware of the above concern on 9/28/2022 at 12:55 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf - Pressure Injury - A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft	F842		

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F842	Continued From page 42 tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (2)This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf - Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss 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 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. 4. The facility staff failed to maintain wound care physician notes in the clinical record for Resident #34. On the most recent MDS assessment, a quarterly assessment, with an ARD of 7/20/2022, the resident scored a 15 out of 15 on the BIMS score, indicating the resident is not cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having one stage IV pressure injury. The facility provided a list of residents with pressure injuries on 9/26/2022. R34 was documented on the list for having an Stage IV pressure injury (1) on their sacrum. The physician order dated, 8/16/2022, documented, "Cleanse sacrum with NSS, pat dry, apply purocol to wound bed and loosely pack with gauze, apply skin prep to the	F842		

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F842	Continued From page 43 surrounding skin and cover with foam dressing every day shift every Tue, Thu, Sat." Review of the clinical record failed to evidence documentation from the wound care physician. A request was made on 9/27/2022 at 2:50 p.m. for the wound care documentation of wound measurements and documentation. A second request was made on 9/27/2022 at 4:52 p.m. for the wound care documentation. The wound care physician notes were received on 9/28/2022 at approximately 8:00 a.m. The wound care physician notes were dated 1/18/2022 through 9/28/2022. On 9/28/22 at 8:43 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked where the notes came from, ASM #2 stated they came from the wound physician's portal. When asked if there were in the paper or electronic record, ASM #2 stated, no. ASM #2 stated LPN (licensed practical nurse) #5 is the only employee who has access to the wound physician's computer software portal. ASM #2 stated the wound physician used to send his notes to the facility but hasn't been sending them since he changed computer software a few months ago. ASM #2 stated wound physician/nurse practitioner notes absolutely should be in the clinical record. ASM #1, the administrator, ASM #2, and LPN #5, were made aware of the above concern on 9/28/2022 at 12:55 p.m. No further information was provided prior to exit.	F842		

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F842	Continued From page 44 (1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf - Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. 5. For Resident 118 (R118), facility staff failed to maintain wound care notes in the clinical record. On the most recent MDS (minimum data set) assessment FOR (R118), a quarterly assessment, with an ARD (assessment reference date) of 09/13/2022, the resident was coded as having both short and long term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. Section M "Determination of Pressure Ulcers / Injury Risk" coded (R118) as having a stage three pressure ulcer. Review of (R118's) clinical record and electronic health record failed to evidence wound care notes for (R118). On 9/28/22 at 8:43 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated LPN (licensed practical nurse) #5 is the only employee who has access to the wound	F842		

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	495217	A. BUILDING _____ B. WING _____	C 09/28/2022

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F842	Continued From page 45 physician's computer software portal. ASM #2 stated the wound physician used to send his notes to the facility but hasn't been sending them since he changed computer software a few months ago. ASM #2 stated wound physician/nurse practitioner notes absolutely should be in the clinical record. On 09/28/2022 at approximately 11:10 a.m., LPN # 5 provided (R118's) wound care notes dated 0517/2022 through 09/20/2022. When asked if the wound notes were in (R118's)) clinical record or electronic health record LPN # 5 stated no and that they should be contained in the resident's clinical record or electronic health record. On 9/28/2022 at approximately 12:30 p.m., ASM # 1, administrator, and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F842		
F849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) 483.70(o) Hospice services. 483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. 483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified	F849	**F849** **1. Corrective Action** **Resident #121 was not harmed by this deficient practice.** **2. Other Potential Residents** **All residents receiving hospice service have the potential to be affected by this deficient practice.** **3. New Measures or Systemic Change** **The Director of Nursing has educated the hospice consultants on the potential adverse effects of not having**	

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F849	Continued From page 46 In paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in 418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and	F849	**immediate access to their documentation. The hospice consultants have agreed to document, and place said documentation in the individual resident's record prior to leaving the Center on the date of the resident visit.** **4. Monitoring** **The Director of Nursing and/or unit managers and/or nursing supervisors will audit random records for residents seen by the wound care consultants to ensure compliance with placing documentation in the resident records prior to leaving the Center. The audits will be conducted weekly for four week and monthly for two months thereafter. The results of these audits will be reported monthly to the QAPI Committee for review and recommendations over the next three months.** **5. Completion Date** **November 9, 2022**	

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F849	Continued From page 47 nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. 483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice	F849		

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F849	Continued From page 48 representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician	F849		

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F849	Continued From page 49 (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. 483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at 483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to coordinate hospice care services for one of 42 residents in the survey sample, Resident #121. The findings include: The facility staff failed to have the hospice care provider's documentation on the clinical record for Resident #121 (R121). On the most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 9/15/2022, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section O - Special Treatments, Programs and Procedures, the resident was coded as	F849		

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F849	Continued From page 50 receiving hospice care during the look-back period. The physician order dated 9/8/2022, documented, "Resident admitted to (Name of hospice) Hospice with diagnosis of sequala CVA (stroke) please call (phone number) with any question or change of condition." Review of the electronic and paper clinical record failed to evidence documentation from the hospice services during their visits. The comprehensive care plan dated, 9/21/2022, documented in part, "Focus: Hospice/Palliative care/pain management need due to terminal illness." The "Interventions" documented in part, "Hospice staff to visit to provide, care, assistance and/or evaluation." A request was made on 9/27/2022 at 12:46 p.m. for a copy of the hospice provider's notes. A second request was made on 9/27/2022 at 4:52 p.m. for the hospice provider's notes. On 9/28/2022 at approximately 8:00 a.m., the hospice provider's notes were presented. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 9/28/2022 at approximately 9:30 a.m. When asked where the hospice provider's notes were obtained from, ASM #1 stated she would have to get the social services to answer that question, they handle dealing with the hospice providers. An interview was conducted with OSM (other staff member) #6, the social services coordinator, and OSM #7, the social worker, on 9/28/2022 at 9:46 a.m. When asked where the	F849		

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F849	Continued From page 51 notes came from, OSM #6 stated she had to call them and have them faxed over. When asked if the hospice notes should be in the clinical record, OSM #6 stated, yes Ma'am. When asked why you should have their notes, OSM #6 stated, it's very important to have them in the physical chart or the electronic chart. When asked if it has anything to do with the coordination of care between the facility and the hospice care provider, OSM #6 stated she would get back with this surveyor. On 9/28/2022 at 9:53 a.m. OSM #6 returned and stated, yes, it can impact the coordination of care. ASM #1, the administrator, ASM #2, the director of nursing, and LPN #5, were made aware of the above concern on 9/28/2022 at 12:55 p.m. No further information was provided prior to exit.	F849		