STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	A. BUILDING _____ B. WING _____	C 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)	2125 HILLIARD ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 100	F 692		

being severely cognitively impaired for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status). R63 was coded as having no significant weight loss during the look back period.

A review of R63's clinical record revealed the following weights on the following dates:
On 12/7/21, the resident weighed 93 lbs. On 1/14/22, the resident weighed 87 pounds. The loss was a 6.45 % loss.

Further review of R63's clinical record revealed no dietary or nutrition notes related to this loss, and no evidence that the provider was notified of this significant weight loss.

A review of R63's care plan dated 10/8/19 and reviewed 3/15/22 revealed, in part: "[R63] has the potential for nutrition/hydration imbalance...BMI (body mass index) is underweight...RD (registered dietician) to monitor and f/u (follow up) per protocol...review weights and notify physician and responsible party of significant weight change."

On 5/19/22 at 9:29 a.m., OSM (other staff member) #12, the RD was interviewed. She stated she has only been working at the facility since March 2022, and was not responsible for reviewing weights for R63 in December 2021 or January 2022. She stated she pulls the weekly weights for at-risk residents and reviews them. She stated if she identifies a significant loss, she would contact the physician, and recommend interventions, if appropriate for the resident. She stated a 6.45% weight loss in 30 days is a significant weight loss, and should have been addressed by the RD at the time. She stated the

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F 692	Continued From page 101 RD should document in the clinical record regarding awareness of the significant weight loss and any interventions recommended to the physician. On 5/19/22 at 5:11 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the policy, "Weight Management Guidelines," revealed, in part: "Potential ongoing management strategies may include...Individualized care planning and consideration of acute illness needs, therapy and treatment...comprehensive medical evaluation." No further information was provided prior to exit.	F 692		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and service for a complete dialysis (1) program for two of 52 residents in the survey sample, Residents #16 (R16) and #149 (R149). The findings include:	F 698		

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F 698	Continued From page 102 1a. The facility staff failed to check (R16's) AV (arterial/venous) fistula (2) site for the thrill/bruit (3) according to the physician's orders. (R16) was admitted to the facility with diagnoses that included but were not limited to: end stage renal disease (4), dependent on renal dialysis. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/24/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R16) for "Dialysis" while a resident. The physician's order summary for (R16) documented in part, "Check AV (arterial/venous) fistula (3) site thrill/bruit (4) every day shift for AV fistula site thrill/bruit check. Order Date: 03/11/2022. Start Date: 03/12/2022." The comprehensive care plan for (R16) dated 05/22/2019 documented in part, "Focus. Renal insufficiencies related to: ESRD (end stage renal disease), dependence on renal dialysis. Date Initiated: 05/22/2019." Under "Interventions" it documented in part, "Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to physician Date Initiated: 05/22/2019." Review of the eTAR (electronic treatment administration record) for (R16) dated March 2022 documented in part, "Check AV fistula site	F 698	698 – Dialysis 1. R16 communication sheets have been implemented and the physician order for monitoring the access site is on-going. R149 communication sheets have been implemented. 2. Utilizing the "hemodialysis" QAPI tool the director of nursing/designee will complete a comprehensive review of current residents on dialysis to validate access site monitoring orders and communication sheets. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on f-tag 698" and the "hemodialysis" nursing procedure on or before the date of compliance. 4. Utilizing the "hemodialysis" QAPI tool – the director of nursing/designee will audit five residents per week times four weeks to validate dialysis communication forms are reviewed and dialysis access site monitoring is completed. Results will be reviewed with the QA&A committee.	6/30/2022

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F 698	Continued From page 103	F 698		

thrill/bruit every day shift for AV fistula site thrill/bruit check." Further review of the eTAR revealed blanks on 03/17/22 and 03/25/2022.

Review of (R16's) eTAR dated April 2022 documented in part, as stated above. Further review of the eTAR revealed blanks (no staff signature) on 04/15/2022, 04/24/2022.

Review of (R16's) eTAR dated May 2022 documented in part, as stated above. Further review of the eTAR revealed a blank on 05/13/2022.

On 05/19/2022 at approximately 2:45 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding the blanks on (R16's) eTARs for March, April and May 2022. After reviewing the eTARs for the dates listed above LPN #5 was asked to interpret the blanks for the bruit and thrill checks. LPN #5 stated that if the eTAR was blank it indicated that the bruit and thrill was not checked.

The facility's policy "Dialysis Guidelines" documented in part, "The patient's medical record includes documentation of ongoing evaluation of the peritoneal catheter, including assessment of catheter related infections and tunnel for condition, monitoring for patency, leaks, infection, and bleeding at the site. Staff monitor for complications such as peritonitis (for example, abdominal pain/tenderness/distention, cloud peritoneal dialysis fluid, fever, nausea and vomiting)."

On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made

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aware of the findings.

No further information was presented prior to exit.

References:
(1) Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.

(2) An abnormal connection between two body parts, such as an organ or blood vessel and another structure. Fistulas are usually the result of an injury or surgery. This information was obtained from the website: https://medlineplus.gov/ency/article/002365.htm

(3) When you slide your fingertips over the site you should feel a gentle vibration, which is called a "thrill." Another sign is when listening with a stethoscope a loud swishing noise will be heard called a "bruit." If both of these signs are present and normal, the graft is still in good condition. This information was obtained from the website: https://www.vascularhealthclinics.org/institutes-divisions/vascular-surgery-and-medicine/dialysis-access/#:~:text=When%20you%20slide%20your%20fingertips,is%20still%20in%20good%20condition.

(4) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

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F 698	Continued From page 105 1b. The facility staff failed to provide complete dialysis communication forms for (R16) on 05/02/2022, 05/04/2022, 05/06/2022, 05/09/2022, 05/11/2022, 05/13/2022, 05/16/2022 and on 05/18/2022. The physician's order for (R16) documented in part, "Hemodialysis per physician order M-W-F (Monday - Wednesday-Friday) 0530-0900 (5:30 a.m. to 9:00 a.m.). Order date: 05/02/2022." The comprehensive care plan for (R16) dated 05/22/2019 documented in part, "Focus. Renal insufficiencies related to: ESRD (end stage renal disease) , dependence on renal dialysis. Date Initiated: 05/22/2019." Under "Interventions" it documented in part, "Coordinate dialysis care with dialysis treatment center Date Initiated: 05/22/2019." Review of the facility's "Hemodialysis Communication Forms" for (R16's) dialysis failed to evidence documentation of the following: description of the dialysis site , patient status, laboratory tests, and the nurse's signature on 05/02/2022, 05/04/2022, 05/06/2022, 05/09/2022, 05/11/2022, 05/13/2022, 05/16/2022 and on 05/18/2022 and (R16's) temperature on 05/02/2022, 05/04/2022, 05/13/2022 and 05/16/2022. On 05/19/2022 at approximately 2:45 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding the facility's "Hemodialysis Communication Forms" for (R16) dated 05/02/2022, 05/04/2022, 05/06/2022, 05/09/2022, 05/11/2022, 05/13/2022, 05/16/2022 and on 05/18/2022. When asked to describe the	F 698		

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procedure for completing the dialysis communication form LPN #5 stated that the top of the form that included vital signs, status of the dialysis site, patient status and signed by the nurse. After reviewing (R16's) dialysis communication forms dated above LPN #5 stated that the forms were incomplete.

The facility's policy "Dialysis Guidelines" documented in part, "Both the center and the dialysis facility are responsible for shared communication regarding patients receiving dialysis services, either onsite or offsite. The Hemodialysis Communication Form (CLS187) is to be used. Collaborative communication includes information regarding: ... physician/treatment orders, laboratory values, and vital signs; dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring including those related to the vascular access site or peritoneal dialysis catheter ..."

On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was presented prior to exit.
2. The facility failed to provide dialysis services including communication with the dialysis facility for Resident #149.

Resident #149 was admitted to the facility on 12/8/21 with diagnosis that included but were not limited to: congestive heart failure, end stage renal disease (ESRD) with hemodialysis (HD), diabetes mellitus and atherosclerotic cardiovascular disease.

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F 698	Continued From page 107 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/29/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, transfer, walking, locomotion, dressing, eating, hygiene and bathing. Section O-special procedures/treatments coded the resident as dialysis "yes". A review of the comprehensive care plan dated 1/18/22, revealed, "FOCUS: Renal insufficiencies related to ESRD-HD presence of fistula/graft INTERVENTIONS: Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Coordinate dialysis care with dialysis treatment center." A review of the physician orders, dated 5/2/22, revealed the following, "Hemodialysis per physician order Tuesday, Thursday, and Saturday." A review of the physician orders, dated 4/24/22, revealed the following, "Check AV fistula site thrill/bruit every day shift. Dialysis site observation every shift and as needed." Resident #149 was at dialysis upon entrance to facility on 5/17/22 and upon return was unable to locate dialysis binder for the resident. On 5/17/22 a request was made for the dialysis communication sheets for Resident #149 from 1/17/22 to 5/17/22. There were 52 scheduled dialysis visits over the course of the 120 day	F 698		

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F 698	Continued From page 108 period. On 5/18/22 at 12:05 PM, ASM (administrative staff member) #2, the director of nursing, provided a sheet which revealed, "Unable to locate dialysis communication forms." A review of the March TAR (treatment administration record) for March 2022, reveals no documentation for AV fistula site for one of 31 days, and no documentation for dialysis site observation every shift for two of 93 shifts. A review of the April TAR, reveals complete documentation for AV fistula site and documentation for dialysis site observation every shift. A review of the May TAR, reveals no documentation for AV fistula site for two of 18 days, and no documentation for dialysis site observation every shift for seven of 54 shifts., On 5/18/22 at 8:20 AM, an interview was conducted with Resident #149. When asked if he had a dialysis binder or paperwork that he takes to the dialysis center, Resident #149 stated, "No, they never send anything with me except my bag lunch." On 5/18/22 at 8:34 AM, an interview was conducted with LPN (licensed practical nurse) #1. When asked the purpose of the dialysis communication book, LPN #1 stated, "The purpose is to send information to the dialysis center about the resident, vital signs, any issues and the dialysis center shares their information with us." When asked the location of the dialysis book for Resident #149, LPN #1 stated, "It should	F 698		

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be here in the nursing station. I work on another unit and that is where we keep them. I cannot find the book here. I do not know if he has a book." When asked what care and checks are provided to a resident on dialysis, LPN #1 stated, "I check their vital signs, check the fistula for bruit, thrill and bleeding."

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

A review of the facility's "Dialysis Guidelines" dated 2017, which revealed, "Both the center and the dialysis facility are responsible for shared communication regarding patients receiving dialysis services. The hemodialysis communication form is to be used. The patient's medical record includes documentation of ongoing evaluation of the

A review of the facility's "End-Stage Renal Disease, Care of a Resident with" revised 9/10, documented in part, "Includes all aspects of how the residents care will be managed including: how the care plan will be developed and implemented, how information will be exchanged between the facilities and responsibility for waste handling, sterilization and disinfection of equipment. Collaborative communication includes information regarding: dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring including those related to the vascular access site."
No further information was provided prior to exit.

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F 730	Continued From page 110	F 730	730 – Nurse Aide Peform Review – 12 hr/yr In-Service 1. CNA #5 and #8 completed training for Abuse/Neglect, Dementia, Emergency Preparedness, and Infection Control on "6/15/22". 2. The Administrator/HRD has reviewed the current nurse aide roster to validate mandatory training. 3. The Administrator has re-educated the Human Resource Director on the tracking of Nurse Aide required training. 4. The Human Resource Director will audit nurse aide training weekly times four to validate compliance with training.	6/30/2022
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined the facility staff failed to provide mandatory training on an annual basis for two of five CNAs (certified nursing assistants), CNA #5 and CNA #8. The findings include: The training records for five CNAs were reviewed. For CNA #5, the documentation, from the computerized training system, was blank. For CNA #8, the computerized training system documented only two trainings. There was no documentation for either CNA for training in abuse, infection control, dementia or emergency preparedness. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 5/18/2022 at 12:11 p.m. When asked who is responsible for education of the staff and their annual training requirements, ASM #2 stated it was a joint effort between the unit managers, the administrator, and the director of nursing. ASM #2 stated the human resources director is responsible for the [name of the computerized			

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F 730	Continued From page 111 training system used]. An interview was conducted on 5/18/2022 at 12:15 p.m. with ASM #1, the administrator and confirmed with ASM #1 that CNA #8 only had two documented trainings and CNA #5 had no documented trainings. ASM #1 stated he couldn't find any other trainings for CNA #5 and CNA #8. ASM #1, ASM #2 and OSM (other staff member) #2, the human resources director, were made aware of the above concern on 5/18/2022 at 4:57 p.m. A request was made on 5/20/2022 for a policy on the mandatory trainings for CNAs. On 5/23/2022 at approximately 2:00 p.m. ASM #2 stated she did not have any other policies.	F 730		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.	F 776		

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F 776	Continued From page 112 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, it was determined that the facility staff failed to obtain timely radiology services for one of 52 residents in the survey sample, Resident #802 (R802). The facility staff failed to take action to prevent a 48 hour delay between an order for an X-ray and completion of the X-ray for R802. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and transfers. A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment." Further review of R802's progress notes revealed no other documentation related to attempts to obtain urgent radiology services for R802's potentially fractured hip.	F 776	776 – Radiology/Other Diagnostic Services 1. R802 no longer resides in the facility. 2. Utilizing the "Change in condition" QAPI tool – a review of current residents with radiology reports from 5.23.2022 will be completed by the director of nursing/designee to validate timely results and notification. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on f-tag 776" and the "change in condition" QAPI tool on or before the date of compliance. 4. Utilizing the "Change in condition" QAPI tool the director of nursing/designee will review five residents per week times four weeks with radiology diagnostics to validate timely completion and clinical documentation. Results will be reviewed with the QA&A committee.	6/30/2022

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A review of the physician's orders for R802 revealed the following order, dated 8/8/22 at 11:27 p.m.: "X-ray to right hip and right knee...for pain to right hip and knee. D/c (discontinue) order once performed." The order was entered by LPN #7.

A review of R802's discharge summary from the local hospital dated 4/21/22 revealed R802 was admitted with a fractured right hip. During the hospital stay from 4/10/22 through 4/21/22, R802 underwent surgery on 4/11/22 to repair the right hip fracture.

A review of R802's comprehensive care plan dated 10/28/21 revealed no information related to a potential hip fracture.

On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. LPN #7 stated she worked 4/8/22, 4/9/22, and 4/10/22, and cared for R802 on each of these days. She stated the X-ray was ordered 4/8/22, but the X-ray company did not arrive at the facility to perform the X-ray until late in the evening on 4/10/22. When asked why X-ray company did not arrive until nearly 48 hours after the order, she stated: "That's not unusual for them." When asked what kind of care the resident received between the time the X-ray was ordered and the X-ray was performed, she stated: "I gave some Tylenol." When asked if R802 was turned and repositioned during the 48 hour gap, she stated the resident was provided incontinence care, and was turned and repositioned frequently. When

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asked if it is best practice to continue to turn and reposition a resident with a potentially fractured hip, she stated she had not thought of it in this way. She stated: "No, it's not. We probably shouldn't have done that." When asked if she made any attempts to contact the X-ray company to determine when they would arrive or to ask if someone could arrive sooner than originally planned, she stated she did not. When asked if she contacted the physician/NP (nurse practitioner) to let them know the X-ray could not be performed immediately, she stated she did not.

On 5/23/22 at 11:14 a.m., LPN #5 was interviewed. When asked about the process for obtaining mobile X-rays, she stated the nurse fills out a form, then calls the mobile X-ray company. She stated the X-ray company usually does not give a time when they anticipate someone will be there to perform the X-ray. She stated if she orders the X-ray at the beginning of her shift and she has not heard from the X-ray company by the end of the shift, she will call the company back to determine a more exact time when the company will arrive to do the X-ray. She stated: "Sometimes they will tell you they will be here the next day because they are so backed up." She stated if a resident has a potential fracture, and the X-ray company cannot come immediately, she calls the provider to let them know that the X-ray is delayed, and will ask the provider what should be done next. She stated the provider will often say to send the resident out to the ER, and not to wait for the mobile X-ray.

On 5/23/22 at 12:44 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. ASM #2 stated that any movement of

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F 776	Continued From page 115 a resident who has a potentially fractured hip could possibly result in further injury of the fracture. She stated the provider should be consulted if an X-ray cannot be obtained immediately. She stated the facility contract with the mobile X-ray company contains time frames for the X-ray company to provide services. She stated staff members have the option to communicate with the company, and to contact the provider if the X-ray cannot be performed timely. On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. ASM #2 stated the facility did not have a policy for obtaining mobile radiology services. No further information was provided prior to exit.	F 776		
F 804 SS=F	Complaint deficiency Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, it was determined that	F 804		

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F 804	Continued From page 116 the facility staff failed to serve meals in a palatable manner from 1 of 1 facility kitchens. The findings include: On 5/18/22 at 12:2 PM, an observation of the tray line was conducted. The following temperatures were observed, with temperatures obtained via a facility thermometer by OSM #6 (Other Staff Member) the Dietary Manager: -Green bean casserole 140 degrees -Potatoes 159 degrees -Breaded chicken 160 degrees -Mechanical chicken 130 degrees. OSM #6 put this back in the oven and rechecked at 12:17 PM at 145 degrees. -Hot dogs 155 degrees -Carrots 162 degrees -Chicken soup 180 degrees -Pureed green beans 130 degrees. OSM #6 put this back in the oven and rechecked at 12:17 PM at 140 degrees. -Pureed chicken 145 degrees at 12:17 PM (was not previously on the tray line.) On 5/18/22 at 1:43 PM a test tray was requested. On 5/18/22 at 1:55 PM the cart with the test tray arrived to the unit (400 hall). On 5/18/22 at 2:04 PM the test tray palatability was conducted and temperatures as obtained via a facility thermometer by OSM #6 were as follows: -Potatoes at 125 degrees. Palatability was very bland, and was not an appetizing temperature, as tested by 2 surveyors and OSM #6. -Breaded chicken at 111 degrees. Palatability	F 804	804 – Nutritive Value/Appear, Palatable/Prefer Temp 1. OSM #6 was re-educated on recipe compliance when preparing meals to include breaded chicken, potatoes, and pureed chicken. 2. The facility monthly menu have been reviewed to validate appropriate menu items are readily available and recipes present. 3. The Food Service Director/Registered Dietician will re-educate cooks are adherence to the recipe when preparing each meal. 4. The Food Service Director/designee will randomly complete a test tray audit weekly times 4 weeks to validate food palatability and temperature. The Administrator will submit findings to the QAPI committee for review and further recommendations.	6/30/2022

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F 804	Continued From page 117 was very bland and was not at an appetizing temperature, as tested by 2 surveyors (OSM #6 stated that they do not eat meat, so they did not taste any meat products.) -Carrots at 100 degrees. Palatability was considered acceptable by 2 surveyors and OSM #6. -Pureed green beans at 115 degrees. Palatability was considered acceptable by 2 surveyors and OSM #6. -Pureed chicken at 110 degrees. Palatability was very bland, not at an appetizing temperature, odd texture, and unappealing paste-like looking, as tested by 2 surveyors. -Unbreaded chicken breast at 105 degrees. Palatability was very bland, dry, and not at an appetizing temperature, as tested by 2 surveyors. (Note: this was used for renal, cardiac, and pureed texture residents). The remaining items as seen in the kitchen were untested due to the kitchen running out of those food items before the test tray was prepared. The facility policy, "Customer Service - Meal Satisfaction" was reviewed. This policy documented, "4..."Food and Drinks - Each resident receives, and the facility provides (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at a safe and appetizing temperature..." On 5/18/22 at 3:34 PM, ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided. COMPLAINT DEFICIENCY	F 804		

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F 812 SS=F	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 that the facility staff failed to store, prepare, and serve food in a safe manner in 1 of 1 facility kitchens. The findings include: On 5/17/22 at 12:19 PM, the kitchen tour was conducted with OSM #6 (Other Staff Member) the Dietary Manager. The following items were observed: -Serving trays were observed wet nesting and dietary staff were hand drying the trays with cloth towels for tray line. -In the walk-in refrigerator: pureed sausage,	F 812	812 – Food Procurement, Store/Prepare/Serve - Sanitary 1. The items not stored properly were discarded on 5/18/22. Kitchen staff present were re-educated on proper food storage and drying and storing of items when manually washing. 2. The administrator has completed an audit of the kitchen to validate proper food storage and drying and storage of items manually washed. 3. The Food Service Director or designee has re-educated the dietary staff on proper food storage and drying/storage of items when manually washed. 4. The Food Service Director or designee will audit the kitchen for proper food storage and the drying and storage of items manually washed weekly times four. The Administrator will submit the findings to the QAPI committee for review and further recommendations.	6/30/2022

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F 812	Continued From page 119	F 812		

pureed eggs, and hash brown potatoes, were covered with foil or plastic wrap and one side of the foil or wrap was pulled back, exposing the food to the environment.
-A pan of cooked cauliflower was covered but not labeled.
-A pan of green beans covered in foil, was on the second shelf of a wire storage rack, with an off-whitish colored liquid dripped onto the foil cover which created a puddle on the foil covering the green beans.
-A box of hot dogs with one package opened, that was only partially rewrapped, was stored on a wire rack shelf, over top of a shelf of fresh produce.
-A half of a deli turkey breast that had been sliced was loosely wrapped with plastic over the open / sliced end, and sitting directly on wire rack shelf with the sliced end down, not in a pan, and over top of a shelf of fresh produce.

On 5/17/22 at approximately 12:40 PM, an interview was conducted with OSM #6. They stated that the meat should not be stored over top of fresh produce, all items should be properly covered, labeled, and dated; and that the trays and dishware should not be wet nesting and should be air dried, not towel dried by hand.

The facility policy, "Three Compartment Sink - Manual Warewashing" was reviewed. This policy documented, "Drying and Storing: 1. Allow items to air dry before storing or store in a manner that allows for air circulation and drying."

The facility policy, "Storage of Food" was reviewed. This policy documented, "6. Store food and stock products in National Sanitation Foundation approved sanitary storage containers

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F 812	Continued From page 120 with lids, or in food quality plastic bags, and label as to contents and date where appropriate....8. Store raw meat, poultry, and fish separately from cooked and raw ready-to-eat food such as fruits and vegetables by arranging each type of food in equipment or containers so that cross contamination is prevented. 9. Defrost protein items (for example, meat, poultry, fish, liquid eggs) under refrigeration, below cooked and raw ready-to-eat foods, with a container to collect drippings..." On 5/18/22 at 3:34 PM, ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		

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F 842	Continued From page 121 §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- (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	F 842	842 – Resident Records – Identifiable Information 1. R145 alert bracelet order continues per physician order. R149 dialysis monitoring continues per physician orders. R132 alert bracelet order continues per physician order. R85 treatments continue per physician orders. R802 no longer resides in the facility. R57 alert bracelet order continues per physician order. 2. The Director of Nurisng or designee will audit current in-house patients eMar/ETars 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on F-tag 842" and "Medication and Treatment: Administration Guidelines" on or before the date of compliance. 4. Utilizing the "medication error" QAPI tool – the director of nursing/designee will audit 10 random patient eMAR/eTAR weekly times four weeks and validate appropriate follow up for documentation omissions. Results will be reviewed with the QA&A committee.	6/30/2022

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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, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to maintain a complete and accurate clinical record for six of 52 residents in the survey sample, Residents #145, #149, #57, #132, #85 and #802.

The findings include:

1. The facility staff failed to document the checking of an alert bracelet for Resident #145 (R145).

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/28/2022, the resident score 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions.

The physician order dated, 9/9/2021, documented, "Alert bracelet - check function every shift. Alert bracelet - check placement every shift."

The TAR (treatment administration record) for April 2022 documented the above orders. For the month of April there were 90 opportunities for documenting the checking of the function of the

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alert bracelet. Of those 90 opportunities, there were five that were not documented on, or blank. The TAR for May 2022 documented the above orders. For the month of May there were 54 opportunities for documenting the checking of the function of the alert bracelet. Of those 54 opportunities, there were eight that were not documented on, or blank.

The comprehensive care plan dated, 1/17/2022 documented in part, "Focus: Exit seeking/elopement risk related to cognitive impairment." The "Interventions" documented in part, "Alert Bracelet. Check alert bracelet placement Q (every) shift and Functioning Q day."

An interview was conducted on 5/19/2022 at 2:38 p.m. with RN (registered nurse) #3. The April and May TAR was shown to RN #3. When asked what the blanks on the TAR indicated, RN #3 stated it was either it was not done or just not signed out.

The facility policy, "Clinical Record Resource Manual" documented in part, "Clinical records are maintained on each patient that are complete, readily accessible and systematically organized. A complete clinical record reports the actual experience of the individual and contains sufficient information to validate patient status and outcomes of care provided. The center maintains information contained in the clinical record as confidential, regardless of the form or storage method of the records. Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition. Any individual who provides care to the patient may document care in the record. Each entry in the record is signed or initialed as appropriate, dated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 124 and timed for the day written and contains the title of the person making the entry. EHR entries are date and time stamped with individual's electronic signature and designation. Opinions that require medical judgment are entered and authenticated by physicians or non-physician practitioners as allowed by scope of practice and collaborative agreement as appropriate. Individuals charting in clinical records are expected to adhere to ethical principles and professional standards. Documentation guidelines are also communicated to all employees who document in the clinical record through the Clinical Documentation Guidelines booklet which is available through Senior Care Brand Central/e-fulfillment." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and OSM (other staff member) #2, human resources, were made aware of the above concern on 5/19/2022 at 5:13 p.m. No further information was provided prior to exit. 2. The facility staff failed to provide a complete and accurate medical record for dialysis care and services for Resident #149. Resident #149 was admitted to the facility on 12/8/21 with diagnosis that included but were not limited to: congestive heart failure, end stage renal disease (ESRD) with hemodialysis (HD), diabetes mellitus and atherosclerotic cardiovascular disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/29/22,	F 842		

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coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, transfer, walking, locomotion, dressing, eating, hygiene and bathing. Section O-special procedures/treatments coded the resident as dialysis "yes".

A review of the comprehensive care plan dated 1/18/22, which revealed, "FOCUS: Renal insufficiencies related to ESRD-HD presence of fistula/graft. INTERVENTIONS: Check access site for lack of thrill/bruit, evidence of infection, swelling, or excessive bleeding per facility guidelines. Coordinate dialysis care with dialysis treatment center."

A review of the physician orders dated 4/24/22, which revealed, "Check AV fistula site thrill/bruit every day shift. Dialysis site observation every shift and as needed."

A review of March 2022 TAR (treatment administration record) revealed the following:
Check AV fistula site thrill/bruit every day shift, one out of 20 shifts with no documentation.
Dialysis site observation every shift and as needed, 3 out of 35 shifts with no documentation.

A review of the April 2022 TAR evidenced documentation was complete.

A review of the May 2022 TAR revealed the following:
Check AV fistula site thrill/bruit every day shift, two out of 18 shifts with no documentation.

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F 842	Continued From page 126 Dialysis site observation every shift and as needed, seven out of 54 shifts with no documentation. An interview was conducted on 5/19/22 at 7:30 AM with RN (registered nurse) #3. When asked what it meant when there were holes (blanks) in the documentation of the TAR, RN #3 stated, it meant that staff did not document treatments ordered. When asked what complete and accurate documentation means, RN #3 stated, it meant that the medical record reflects care given and all documentation is complete. An interview was conducted on 5/19/22 at 11:30 AM with LPN (licensed practical nurse) #5. When asked what holes in documentation on the TAR mean, LPN #5 stated, "It usually means we were busy and did not get to complete documentation." When asked if there are holes in the documentation, is that indicative of a complete and accurate medical record, LPN #5 stated, "No, it is not complete." On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings. According to the facility's policy "Clinical Records Resource Manual" dated 3/2022, which reveals, "Clinical records are maintained on each patient that are complete, readily accessible and systematically organized. Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition. Chart entries are documented as close to the time of the event as possible, prior to the conclusion of	F 842		

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the shift during which patient care was given. Medication and treatment records are derived from the physician orders and document the delivery of ordered services."

No further information was provided prior to exit.

3. The facility staff failed to provide a complete and accurate medical record for wander guard placement and functioning for Resident #57.

Resident #57 was admitted to the facility on 5/28/21 with diagnosis that included but were not limited to: dementia, cerebrovascular accident, chronic kidney disease and psychosis.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/10/22, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, hygiene and bathing; supervision for locomotion and eating. Section P-restraints/alarms coded the resident as wander/elopement guard used daily.

A review of the comprehensive care plan dated 3/17/22 documented in part, "FOCUS: Exit seeking/ elopement risk (pushing on doors, shaking door handles) related to: cognitive impairment. INTERVENTIONS: ALERT BRACELET. Check alert bracelet placement Q Shift and Functioning Q Day. '

A review of the physician orders dated 3/17/22,

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F 842	Continued From page 128 which revealed, "Alert bracelet - check function on night shift. Alert bracelet - check placement Q shift." A review of March 2022 TAR (treatment administration record) revealed the following: Alert bracelet - check function on night shift: no shifts missing documentation. Alert bracelet - check placement Q shift: one of 54 shifts missing documentation. A review of the April 2022 TAR reveals the following: Alert bracelet - check function on night shift: 3 of 30 shifts missing documentation. Alert bracelet check placement Q shift: 5 of 90 shifts missing documentation. A review of the May 2022 TAR reveals the following: Alert bracelet - check function on night shift: one of 18 shifts missing documentation. Alert bracelet - check placement Q shift: 7 out of 54 shifts missing documentation. An interview was conducted on 5/19/22 at 7:30 AM with RN (registered nurse) #3. When asked what it meant when there were holes (blanks) in the documentation of the TAR, RN #3 stated, it meant that staff did not document treatments ordered. When asked what complete and accurate documentation means, RN #3 stated, it meant that the medical record reflects care given and all documentation is complete. An interview was conducted on 5/19/22 at 11:30 AM with LPN (licensed practical nurse) #5. When asked what holes in documentation on the TAR mean, LPN #5 stated, "It usually means we were busy and did not get to complete documentation." When asked if there are holes in the	F 842		

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documentation, is that indicative of a complete and accurate medical record, LPN #5 stated, "No, it is not complete."

On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings.

According to the facility's policy "Clinical Records Resource Manual" dated 3/2022, which reveals, "Clinical records are maintained on each patient that are complete, readily accessible and systematically organized. Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition. Chart entries are documented as close to the time of the event as possible, prior to the conclusion of the shift during which patient care was given. Medication and treatment records are derived from the physician orders and document the delivery of ordered services."

No further information was provided prior to exit.

4. The facility staff failed to provide a complete and accurate medical record for wander guard placement and functioning for Resident #132.

Resident #132 was admitted to the facility on 11/12/21 with diagnosis that included but were not limited to: traumatic hemorrhage of the cerebrum, transient ischemic attack and hypertension.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/18/22, coded the resident as scoring a 12 out of 15 on

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the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, transfer, walking, locomotion, dressing, eating, hygiene and bathing. Section P- restraints/alarms coded the resident as wander/elopement guard used daily.

A review of the comprehensive care plan dated 2/20/22 documented in part, "FOCUS: Exit seeking/ elopement risk (exited facility without authorization) related to: cognitive impairment. INTERVENTIONS: ALERT BRACELET. Check alert bracelet placement Q Shift and Functioning Q Day."

A review of the physician orders dated 2/20/22, which revealed, "Alert bracelet - check function on night shift. Alert bracelet - check placement Q shift."

A review of March 2022 TAR (treatment administration record) reveals the following: Alert bracelet - check function on night shift: zero shifts missing documentation. Alert bracelet - check placement Q shift: 2 of 93 shifts missing documentation.

A review of the April 2022 TAR reveals the following: Alert bracelet - check function on night shift: 3 of 30 shifts missing documentation. Alert bracelet check placement Q shift: five of 90 shifts missing documentation.

A review of the May 2022 TAR reveals the following: Alert bracelet - check function on night shift: one of 18 shifts missing documentation.

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F 842	Continued From page 131 Alert bracelet - check placement Q shift: 7 of 54 shifts missing documentation. An interview was conducted on 5/19/22 at 7:30 AM with RN (registered nurse) #3. When asked what it meant when there were holes in the documentation of the TAR, RN #3 stated, it meant that staff did not document treatments ordered. When asked what complete and accurate documentation means, RN #3 stated, it meant that the medical record reflects care given and all documentation is complete. An interview was conducted on 5/19/22 at 11:30 AM with LPN (licensed practical nurse) #5. When asked what holes in documentation on the TAR mean, LPN #5 stated, "It usually means we were busy and did not get to complete documentation." When asked if there are holes in the documentation, is that indicative of a complete and accurate medical record, LPN #5 stated, "No, it is not complete." On 5/19/22 at approximately 5:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM #2, the director of human resources were made aware of the findings. According to the facility's policy "Clinical Records Resource Manual" dated 3/2022, which reveals, "Clinical records are maintained on each patient that are complete, readily accessible and systematically organized. Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition. Chart entries are documented as close to the time of the event as possible, prior to the conclusion of the shift during which patient care was given.	F 842		

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F 842	Continued From page 132 Medication and treatment records are derived from the physician orders and document the delivery of ordered services." No further information was provided prior to exit. 5. The facility staff failed to maintain a complete and accurate clinical record regarding documenting treatments completed for Resident #85 (R85). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) 3/21/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. Section M documented R85 having five stage 3 pressure ulcers and one unstageable pressure ulcer. The current physician order's for R85 documented in part: - "Order Date: 3/10/2022. Cleanse appy [sic] Medihonery [sic] Alginate to L (left) lateral foot, apply skin prep to peri-wound. Cover wound bed with TAO (triple antibiotic ointment) and cover with bandaid or dry dressing TIW (three times a week) daily and PRN (as needed)." - "Order Date: 3/10/2022. Cleanse pressure wound to left heel with wound cleanser, pat dry, cover with Hydrofera Blue Ready transfer, cover with dry dressing ABD (gauze pad), secure with kling/cast padding and stretch net daily." - "Order Date: 3/10/2022. Cleanse pressure wound to left ischium with wound cleanser apply skin prep to peri-wound, apply Anasept 0.57% moist gauze, cover with Silicone Adhesive to wound bed and cover with dry dressing daily and	F 842		

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F 842	Continued From page 133 PRN." - "Order Date: 3/10/2022. Cleanse pressure wound to right heel with wound cleanser, pat dry, apply skin prep to peri-wound, apply Medihoney Alginate to wound bed and cover with dry dressing daily and PRN." - "Order Date: 3/19/2022. Cleanse pressure wound to sacrum with wound cleanser, pat dry, cover with Hydrofera blue Ready Transfer, cover with Silicone Adhesive to wound bed, cover with dry dressing daily." - "Order Date: 3/19/2022. Cleanse pressure wound to right ischium with wound cleanser, pat dry, apply skin prep to peri-wound, apply Hydrofera Blue Transfer, cover with Silicone Adhesive to wound daily and PRN." - "Order Date: 12/3/2021. Cleanse penis and scrotum with soap and water, apply zinc oxide barrier cream every shift and PRN" - "Order Date: 8/17/2021. Lac-Hydrin Lotion 12 % (Ammonium Lactate) Apply to bilat (bilateral) feet topically every day shift for thick dry skin apply during wound care." - "Order Date: 8/13/2021. Zinc Oxide Paste 40 %, Apply to Left ischium topically every day and evening shift for wound care AND Apply to Left ischium topically as needed for wound care." - "Order Date: 8/13/2021. Zinc Oxide Paste 40 %, Apply to Right ischium topically every day and evening shift for wound care AND Apply to Right ischium topically as needed for wound care." - "Order Date: 7/20/2020. Type - Colostomy LLQ (left lower quadrant) Wafer: Hollister #14804 Bag: Hollister #18194 as needed for colostomy care AND every day shift every 3 day(s) for Colostomy Care." The eTAR (electronic treatment administration record) for R85 dated 4/1/2022-4/30/2022 failed	F 842		

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F 842	Continued From page 134 to evidence documentation for the following treatments on the following dates: - "Cleanse appy [sic] Medihonery [sic] Alginate to L lateral foot, apply skin prep to peri-wound. Cover wound bed with TAO and cover with bandaid or dry dressing TIW daily and PRN (as needed)." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m. and 4/26/2022 at 6:30 a.m. - "Cleanse pressure wound to left heel with wound cleanser, pat dry, cover with Hydrofera Blue Ready transfer, cover with dry dressing ABD, secure with kling/cast padding and stretch net daily." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m. and 4/26/2022 at 6:30 a.m. - "Cleanse pressure wound to left ischium with wound cleanser apply skin prep to peri-wound, apply Anasept 0.57% moist gauze, cover with Silicone Adhesive to wound bed and cover with dry dressing daily and PRN." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m. and 4/26/2022 at 6:30 a.m. - "Cleanse pressure wound to right heel with wound cleanser, pat dry, apply skin prep to peri-wound, apply Medihoney Alginate to wound bed and cover with dry dressing daily and PRN." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m. and 4/26/2022 at 6:30 a.m. - "Cleanse pressure wound to sacrum with wound cleanser, pat dry, cover with Hydrofera blue Ready Transfer, cover with Silicone Adhesive to wound bed, cover with dry dressing daily." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m., 4/16/2022 at 2:30 p.m., 4/20/2022 at 2:30 p.m., and 4/26/2022 at 6:30 a.m.	F 842		

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F 842	Continued From page 135 - "Cleanse pressure wound to right ischium with wound cleanser, pat dry, apply skin prep to peri-wound, apply Hydrofera Blue Transfer, cover with Silicone Adhesive to wound daily and PRN." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m., 4/16/2022 at 2:30 p.m., 4/20/2022 at 2:30 p.m., and 4/26/2022 at 6:30 a.m. - "Cleanse penis and scrotum with soap and water, apply zinc oxide barrier cream every shift and PRN" On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m., 4/20/2022 at 2:30 p.m., and 4/26/2022 at 6:30 a.m. - "Lac-Hydrin Lotion 12 % (Ammonium Lactate) Apply to bilat feet topically every day shift for thick dry skin apply during wound care." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m. and 4/26/2022 at 6:30 a.m. - "Zinc Oxide Paste 40 %, Apply to Left ischium topically every day and evening shift for wound care AND Apply to Left ischium topically as needed for wound care." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m., 4/16/2022 at 2:30 p.m., 4/20/2022 at 2:30 p.m., and 4/26/2022 at 6:30 a.m. - "Zinc Oxide Paste 40 %, Apply to Right ischium topically every day and evening shift for wound care AND Apply to Right ischium topically as needed for wound care." On 4/7/2022 at 6:30 a.m., 4/11/2022 at 6:30 a.m., 4/15/2022 at 6:30 a.m., 4/16/2022 at 2:30 p.m., 4/20/2022 at 2:30 p.m., and 4/26/2022 at 6:30 a.m. - "Type - Colostomy LLQ (left lower quadrant) Wafer: Hollister #14804 Bag: Hollister #18194 as needed for colostomy care AND every day shift every 3 day(s) for Colostomy Care." On 4/11/2022 at 6:30 a.m. and 4/26/2022 at 6:30 a.m.	F 842		

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F 842	Continued From page 136 The eTAR dated for R85 dated 5/1/2022-5/31/2022 failed to evidence documentation for the following treatments on the following dates: - "Cleanse appy [sic] Medihonery [sic] Alginate to L lateral foot, apply skin prep to peri-wound. Cover wound bed with TAO and cover with bandaid or dry dressing TIW daily and PRN." On 5/15/2022 at 6:30 a.m. - "Cleanse pressure wound to left heel with wound cleanser, pat dry, cover with Hydrofera Blue Ready transfer, cover with dry dressing ABD (gauze pad), secure with kling/cast padding and stretch net daily." On 5/15/2022 at 6:30 a.m. - "Cleanse pressure wound to left ischium with wound cleanser apply skin prep to peri-wound, apply Anasept 0.57% moist gauze, cover with Silicone Adhesive to wound bed and cover with dry dressing daily and PRN." On 5/15/2022 at 6:30 a.m. - "Cleanse pressure wound to right heel with wound cleanser, pat dry, apply skin prep to peri-wound, apply Medihoney Alginate to wound bed and cover with dry dressing daily and PRN." On 5/15/2022 at 6:30 a.m. - "Cleanse pressure wound to sacrum with wound cleanser, pat dry, cover with Hydrofera blue Ready Transfer, cover with Silicone Adhesive to wound bed, cover with dry dressing daily." On 5/4/2022 at 2:30 p.m. and 5/15/2022 at 6:30 a.m. - "Cleanse pressure wound to right ischium with wound cleanser, pat dry, apply skin prep to peri-wound, apply Hydrofera Blue Transfer, cover with Silicone Adhesive to wound daily and PRN." On 5/4/2022 at 2:30 p.m. and 5/15/2022 at 6:30 a.m. - "Cleanse penis and scrotum with soap and water, apply zinc oxide barrier cream every shift	F 842		

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F 842	Continued From page 137 and PRN" On 5/4/2022 at 2:30 p.m. - "Zinc Oxide Paste 40 %, Apply to Left ischium topically every day and evening shift for wound care AND Apply to Left ischium topically as needed for wound care." On 5/4/2022 at 2:30 p.m. and 5/15/2022 at 6:30 a.m. - "Zinc Oxide Paste 40 %, Apply to Right ischium topically every day and evening shift for wound care AND Apply to Right ischium topically as needed for wound care." On 5/4/2022 at 2:30 p.m. and 5/15/2022 at 6:30 a.m. The progress notes for R85 failed to evidence documentation of treatments completed or refused on the dates listed above. On 5/19/2022 at 9:10 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that treatments were evidenced as completed by documenting them on the eTAR. LPN #6 stated that resident refusals were also documented on the eTAR and on the progress notes. LPN #6 stated that they notified the residents responsible party and physician when they refused care. When asked what blanks in the treatment areas on the eTAR meant, LPN #6 stated that they were not sure and that the nurse probably did not document the treatment or refusal. LPN #6 stated that R85 frequently refused treatments and the nurse may have forgotten to document. On 5/19/2022 at 9:30 a.m., an interview was conducted with RN (registered nurse) #1, unit manager. RN #1 stated that treatments were evidenced as completed by documenting them in the progress notes, on the dressings and on the eTAR. When asked what blanks on the eTAR meant, RN #1 stated that it meant that someone	F 842		

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F 842	Continued From page 138	F 842		

did not sign off on the treatment in the computer. RN #1 stated that the eTAR was not complete with blanks on it. RN #1 stated that there should be notes in the record if the resident refused the treatment.

On 5/19/2022 at 5:11 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and OSM (other staff member) #2, the human resource director were made aware of the findings.

No further information was provided prior to exit.

6. The facility staff failed to update Resident #802's (R802) clinical record with acute changes in condition, resident report of injury, and assessment results for the resident in April 2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and transfers.

A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical nurse) #7. "Patient's X-ray was positive for subcapital fracture of the right hip. MD (medical doctor) on call was [name of MD] was made aware and patient was sent to [name of local hospital] ER (emergency room) for evaluation and treatment."

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F 842	Continued From page 139 Further review of R802's progress notes revealed no other documentation related to the circumstances surrounding R802's injury, conversations with the provider, or nursing assessments of R802's injury. A review of R802's comprehensive care plan dated 10/28/21 revealed no information related to hip fracture. On 5/19/22 at 1:05 p.m., LPN #7 was interviewed. She stated she remembered R802 very well. She stated on 4/8/22, she contacted the physician because R802 reported right hip pain, and R802's legs were swollen. The physician ordered an ultrasound of both legs and an X-ray of the hip. When asked if she documented any of these findings or conversations, she stated she thought she had. After reviewing R802's progress notes, LPN #7 stated she must have "just missed it." She stated she should have documented the assessment findings and the conversation with the provider in the progress notes. LPN #7 stated that on 4/10/22 early in the evening shift (3:00 p.m. - 11:00 p.m.), she learned that R802 had reported to another staff member that R802 was handled roughly by a TNA (temporary nursing assistant) earlier in the week, and R802 believed that the rough handling was the source of the hip pain. LPN #7 stated she immediately reported this to the supervisor and to ASM (administrative staff member) #2, the DON (director of nursing). When asked if she documented any of these conversations, she stated she did not. She stated: "I just did not think of it at the time." She repeated that she should have documented these conversations. On 5/23/22 at 11:14 a.m., LPN #5 was	F 842		

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F 842	Continued From page 140 interviewed. She stated all nursing care should be documented. She stated there are several options for nursing documentation, including progress notes, pain assessments, medication administration notes, and other formal assessments in the EMR (electronic medical record). She stated all nursing care should be documented because it helps the whole staff take better care of the resident. She stated, "If it's not documented, it's technically not done." When asked if the resident's record is complete and accurate if the nursing documentation is not completed, she said the record is incomplete. On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.	F 842		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced	F 868		

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F 868	Continued From page 141 by: Based on staff interview and facility document review, it was determined that the facility staff failed to hold quarterly meetings of the QAPI (quality assurance performance improvement) committee as required. The facility QAPI committee failed to meet in all four quarters of 2020 and 2021, and in the first quarter of 2022. The findings include: On 5/17/22 at 12:00 p.m., and entrance conference was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. At this time, evidence of QAPI committee meetings since the last survey were requested. On 5/17/22 at 4:36 p.m., ASM #1 provided QAPI policies and procedures, as well as the facility's QAPI plan. ASM #1 provided no evidence that the QAPI committee met during 2020, 2021, or during the first quarter of 2022. On 5/19/22 at 5:11 p.m., evidence of QAPI committee meetings during 2020, 2021, and the first quarter of 2022 were again requested from ASM #1. On 5/23/22 at 1:15 p.m., ASM #1 and ASM #2 were interviewed regarding required QAPI committee meetings. ASM #1 stated he had been in touch with the previous administrator, but had not yet been able to locate any evidence of QAPI committee meetings for the requested dates. When asked how often the QAPI committee meets, ASM #2 stated she did not remember because she does not set the schedule. When asked who sets the QAPI committee meeting	F 868	868 – QAA Committee 1. The Administrator conducted a QAPI meeting on 5/26/22. A QAPI meeting has been scheduled for 6/9/2022. 2. The Administrator has created a monthly QAPI calendar for the year. 3. The Administrator was re-educated on the QAPI meeting scheduling and process by the Regional Director of Operations. 4. The Regional Director of Operations or the Regional Quality Assurance Consultant will validate QAPI calendar has been created for the year. The Regional Quality Assurance Consultant or Regional Director of Operations will audit QAPI meeting minutes monthly times one.	6/30/2022

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F 868	Continued From page 142 schedule, ASM #2 deferred to ASM #1. ASM #1 did not answer. ASM #2 stated: "Most of the time, the [QAPI] meetings are ad hoc. When asked who is on the QAPI committee, ASM #1 stated the physician will attend, if he is available. ASM #1 stated if the physician is unavailable for a set meeting time, the physician will not attend. A review of the facility document, "QAPI Plan," revealed, in part: "The QAPI committee...will consist of the medical director, the director of nursing...and other staff as required...the committee will meet at least quarterly." No further information was provided prior to exit.	F 868		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

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F 883	Continued From page 143 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that during the immunization record review, that the facility staff failed to offer, obtain consent for, and/or provide education regarding the influenza and	F 883	883 – Influenza and Pneumococcal immunizations 1. R83 will be offered the pneumonia vaccine. R132 will be offered the pneumonia vaccine. 2. A review of current resident's immunizations will be completed by the director of nursing/designee to validate compliance. 3. The director of nursing/designee will educate the licensed nursing staff on "Focus on F-tag 883" on or before the date of compliance. 4. The director of nursing/designee will audit five residents per week times four weeks to validate immunizations are current and offered if needed. Results will be reviewed with the QA&A committee.	6/30/2022

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F 883	Continued From page 144	F 883		

pneumococcal vaccines for two of five residents reviewed, Residents #83 (R83) and #132 (R132).

The findings include:

1. The facility staff failed to offer, obtain consent for, and provide education regarding the influenza and pneumococcal vaccines for (R83).

On the most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 03/28/2022, the resident scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions. Under Section "O Special Treatments, Procedures and Programs" (R83) was coded as not being offered the influenza vaccine and under "O300 Is the Resident's Pneumococcal vaccine up to date?" (R83) was coded "No."

A review of the (R83's) clinical record and EHR [electronic health record] failed to evidence a consent and education for the influenza and pneumococcal vaccine.

On 05/19/2022 at approximately 2:14 p.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about the consent and education provided to (R83) regarding the influenza and pneumococcal vaccines ASM # 2 stated that they did not have them.

The facility's policy "Screening and Vaccinations. Section 2: Pneumococcal" documented in part, "Pneumococcal vaccines are offered upon admission and also offered annually during the influenza season to patients/residents who have

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F 883	Continued From page 145 never been vaccinated with a pneumonia vaccine or who have refused to be vaccinated in the past." Under "Section 4: Influenza" it documented in part, "Patients/residents are offered the vaccination and are immunized as a group at the onset of the influenza season. Patients/residents not included in the initial group vaccination are offered the vaccination when admitted throughout the year until the vaccine expires or is no longer available for that season." On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made aware of the findings. No further information was presented prior to exit. 2. The facility staff failed to offer, obtain consent for, and provide education regarding the influenza and pneumococcal vaccines for (R132). On the most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 04/18/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions. Under Section "O Special Treatments, Procedures and Programs" (R132) was coded as not being offered the influenza vaccine and under "O300 Is the Resident's Pneumococcal vaccine up to date?" (R132) was coded "No." A review of the (R132's) clinical record and EHR [electronic health record] failed to evidence a consent and education for the influenza and pneumococcal vaccine.	F 883		

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F 883	Continued From page 146 On 05/19/2022 at approximately 2:14 p.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about the consent and education provided to (R132) regarding the influenza and pneumococcal vaccines ASM # 2 stated that they did not have them. On 05/19/2022 at approximately 5:10 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made aware of the findings. No further information was presented prior to exit.	F 883		
F 888 SS=G	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and	F 888		

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F 888	Continued From page 147 (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely	F 888	888 – COVID-19 Vaccination of Facility Staff 1. Exemptions for each of the following were received on May 19, 2022, OSM #14, 15, 16, 17, 18, CNA #11, 12, 13, 14, 15, and 16. 2. The administrator has reviewed and approved the vaccination/exemption records report for all staff members of the center. 3. The administrator will re-educate the human resources director on the center's vaccination requirements upon hire to ensure that vaccination cards or approved exemptions are present prior to providing direct care. 4. The administrator will audit the vaccination records for all staff members of the center weekly times four weeks. The Administrator will submit audit findings to the QAPI committee for further review and further recommendations.	6/30/2022

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F 888	Continued From page 148 documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of	F 888		

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F 888	Continued From page 149 staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to meet staff vaccination requirements, 15 residents tested positive for COVID-19, and the facility staff failed implement their policy for COVID-19 vaccination for 11 of 166 employee records reviewed. The facility records documented that 15 residents had tested positive for COVID-19 during the previous four weeks but did not require hospitalization; and the facility staff failed to provide evidence of approval of the employee's vaccination exemption as a condition of employment according to the facility's policy. The findings include:	F 888		

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On 05/17/2022 the facility provided a document listing residents who tested positive for COVID-19 from 04/19/2022 through 05/13/2022 as requested.

Review of the facility's COVID-19 employee vaccination matrix revealed that 11 of 166 employees were coded as "Not vaccinated" and their exemption was "Pending."

The facility's vaccine exemption form for OSM (other staff member) # 14, housekeeper, documented the form was signed by OSM #14, on 11/27/21. Review of OSM #14's employee record with OSM #2, human resource director, on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 04/25/2021. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for OSM #15, dietary aide, documented the form was signed by OSM #15 on 04/19/2022. Review of OSM #15's employee record with OSM #2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 04/26/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for OSM #16, payroll, documented the form was signed by OSM #16 on 04/21/2022. Review of OSM #16's employee record with OSM #2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 03/30/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for OSM

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#17, dietary aide, documented the form was signed by OSM #17 on 04/2022. Review of OSM #17's employee record with OSM #2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 03/16/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for OSM #18, dietary aide, documented the form was signed by OSM #18 on 04/25/2022. Review of OSM #18's employee record with OSM #2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 04/06/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for CNA (certified nursing assistant) #12 , temporary nursing aide, documented the form was signed by CNA #12 on 04/21/2022. Review of CNA #12's employee record with OSM #2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 05/12/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for CNA #13, temporary nursing aide, documented the form was signed by CNA #13 on 04/28/2022. Review of CNA #13's employee record with OSM #2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 03/24/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for CNA #14 , temporary nursing aide, documented the form was signed by CNA #14 on 05/12/2022. Review of CNA #14's employee record with OSM # 2 on

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05/19/2022 at approximately 10:20 a.m., revealed a hire date of 04/05/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for CNA #15, temporary nursing aide, documented the form was signed by CNA #15 on 05/13/2022. Review of CNA #15's employee record with OSM # 2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 03/16/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for CNA #16, documented the form was signed by CNA #16 on 05/12/2022. Review of CNA #16's employee record with OSM #2, on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 03/02/2022. Further review failed to evidence an approved or unapproved exemption.

The facility's vaccine exemption form for CNA #11, temporary nursing aide, documented the form was signed by CNA #11 on 04/21/2022. Review of CNA #11's employee record with OSM #2 on 05/19/2022 at approximately 10:20 a.m., revealed a hire date of 03/24/2022. Further review failed to evidence an approved or unapproved exemption.

On 05/17/2022 at approximately 12:00 p.m., during the entrance conference, ASM (administrative staff member) #2, director of nursing, stated that they were the facility's infection preventionist.

On 05/18/2022 at approximately 10:30 a.m., an interview was conducted with ASM #2. After

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reviewing the facility document listing residents who tested positive for COVID-19 from 04/19/2022 through 05/13/2022, ASM # 2 was asked if any of the residents on the list were hospitalized due to testing positive for COVID-19. ASM # 2 stated that none of the residents on the list were hospitalized.

Review of residents listed who tested positive for COVID-19 from 04/19/2022 through 05/13/2022 failed to evidence they were hospitalized due to COVID-19.

On 05/19/2022 at approximately 10:20 a.m., an interview was conducted with OSM #2 regarding the facility's vaccination exemption approval procedure. When asked what the abbreviation "PN" represented on the facility's COVID-19 employee vaccination matrix OSM #2 stated that the employee's exemptions were waiting to be approved. OSM #2 stated that when an employee completes the facility's exemption, either medical or religious exemption, it is emailed to their corporate office for approval. OSM #2 further stated that the facility's corporate office will send an email back to the facility indicating if the employee's exemption is approved. When asked how the corporate office indicates approval of the exemption OSM #2 stated that the email documents "Approved." When asked what the time frame was for an employee's exemption approval OSM #2 stated that there was no specific time frame for the approval. When asked about the exemption approvals for the employees listed above OSM #2 stated that they did not have the approvals. When asked when the exemptions for the employees listed above were emailed to their corporate office OSM #2 stated that they did not

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send them to the corporate office and did not know if anyone had sent them.

On 05/19/22 at approximately 4:00 p.m., an interview was conducted with ASM #2, director of nursing. When asked what special precautions are in place for unvaccinated staff to do direct care for unvaccinated residents ASM #2 stated that unvaccinated staff are tested twice weekly and when giving care they use an N95 mask, face shield, gown and gloves. ASM #2 also stated that the N95 mask and face shield were worn by unvaccinated staff all the time.

On 05/20/2022 at 10:00 a.m., ASM #1, administrator, and ASM #2, director of nursing were informed that there was a concern for harm.

On 05/23/2022 at 11:30 a.m., an interview was conducted with ASM #2, director of nursing. When asked to describe the COVID-19 vaccination procedure for new employees ASM #2 stated that new hires need to be vaccinated but didn't know if it was before they start working and they would have to look it up in the facility's policy. When restated the procedure for an employee's exemption describe by OSM #2 as stated above ASM #2 stated that the procedure was that the employee completed the exemption form prior to employment and sent to the corporate office for approval.

The facility's policy "Mandatory COVID-19 Vaccination Policy" with a "Review/Revised Date: 3/4/2022" documented in part, "VIII. NEW HIRES. Potential candidates for employment will be notified of the requirements of this policy prior to the start of employment. All new employees are required to comply with the vaccination

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F 888	Continued From page 155 requirements (as defined by CMS) (Centers of Medicare/Medicaid Services) outlined in this policy as a condition of employment ...If not vaccinated upon hire, new employees receive their first dose of vaccination or complete the exemption process (see Section IV. EXEMPTIONS) prior to providing any care, treatment, or other services for a [Name of Corporation] facility and/or its patients." Under "IV. EXEMPTIONS" it documented, "Employees may request an exemption from mandatory vaccination if the vaccine is medically contraindicated for them or medical necessity requires a delay in vaccination. Employees also may be legally entitled to a reasonable accommodation if they cannot be vaccinated and/or wear a face covering (as otherwise required by this policy) because of a disability, or if the provisions in this policy for vaccination, and/or testing for COVID-19, and/or wearing a face covering conflict with a sincerely held religious belief, practice, or observance. Requests for exemptions must be initiated by completing the Request for A Medical Exemption to the COVID-19 Vaccination Requirement form or the Request for A Religious Exemption to the COVID-19 Vaccination Requirement form. See Appendix A, Exemption Forms. All such requests will be handled in accordance with applicable laws and regulations." No further information was provided prior to exit.	F 888		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must-	F 947		

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F 947	Continued From page 156 §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined the facility staff failed to provide annual performance evaluations for five of five CNAs (certified nursing assistants) reviewed, CNA # 4, CNA #5, CNA #6, CNA #7, and CNA #8. The findings include: Five employee records were reviewed for the documentation of an annul performance review. The following documentation was presented: CNA #4 was hired on 7/16/2012. A "Performance Appraisal" was dated 10/16/2020. No further documents were provided. CNA #5 was hired on 2/15/2017. A "Performance Appraisal" was dated 5/30/2019. No further documents were provided. CNA #6 was hired 3/6/2019. There was no	F 947	947 - Required In-Service Training for Nurse Aides 1. CNA #4, 5, 6, 7, and 8 performance evaluations were completed on 6/15/22 and will be reviewed with the respective employee during their next scheduled shift. 2. The administrator has reviewed the nurse aide performance evaluation process for the center 3. The Administrator has re-educated the department managers and human resources director on the timely completion of performance evaluations. 4. The Human Resource Director or designee will audit employee performance evaluations due weekly times four weeks to validate completion. The Administrator will submit audit findings to the QAPI committee for further review and further recommendations.	6/30/2022

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"Performance Appraisal" provided.
CNA #7 was hired on 4/11/2007. A "Performance Appraisal" was dated 7/25/2019. No further documents were provided.
CNA #8 was hired on 2/5/2020. There was no "Performance Appraisal" provided.

An interview was conducted with OSM (other staff member) #2, the human resources director, on 5/19/2022 at 9:19 a.m. When asked the process for CNAs to get their annual performance reviews, OSM #2 stated if an employee is hired in January then they should have an appraisal in 12 months and then every 12 months thereafter as long as they are employed. When asked who does the CNA appraisals, OSM #2 stated the nurses or the unit managers. When asked how the nurses and unit managers know when it's time for a CNA to have their annual appraisal, OSM #2 stated when it's time to have them done, the human resources director, hands a list to each department head and then the department head hands it to the appropriate people. When asked why the facility is so far behind in conducting performance reviews, OSM #2 stated she could not answer that because she is only filling in at the facility, the previous human resources director left in April.

The facility policy, "Skills and Techniques Evaluations" documented in part, "The Skills and Techniques Evaluation is re-validated annually at the time of the employee's annual performance evaluation...The nursing assistant's immediate supervisor or designee is responsible for completion of the annual review at the time of the nursing assistant's annual performance evaluation...The human resources director (HRD) is responsible for maintaining employee records

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F 947	Continued From page 158 involving performance appraisals and in-service records." ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concerns on 5/23/2022 at 1:18 p.m. No further information was provided prior to exit.	F 947		