STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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F 000	INITIAL COMMENTS An unannounced Complaints/Facility Reported Incidents survey was conducted at this facility on February 28, 2022 - March 01, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 160 and the survey sample included four residents. The following complaints and facility reported incidences were investigated during this survey: DC00010259, DC00010301, DC00010522, DC00010582, and DC00010587. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day BIMS - Brief Interview for Mental Status B/P - Blood Pressure cm - Centimeters CPR - Cardiopulmonary resuscitation CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility DVT - Deep Vein Thrombosis D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EHR - Electronic Health Record	F 000	**SERENITY REHABILITATION AND HEALTH CENTER DISCLAIMER** Facility submits this plan of correction under procedures established by the Department of Health. In order to comply with the Department's directive to change conditions which the Department alleges are deficient under state Regulations relating to long term care. This should not be construed as either a waiver of the Facility's right to appeal and to Challenge the accuracy or severity of the alleged Deficiencies or any admission of any wrong doing.	05/16/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Funmilayo Fashola — TITLE: LNHA — (X6) DATE: 04-26-2022

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

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F 000	Continued From page 1 EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ESRD - End Stage Renal Disease G-tube Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASARR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PPE - Personal Protective Equipment PO- by mouth POS - physician's order sheet Prn - As needed Pt - Patient Q- Every RN - Registered Nurse ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		05/16/2022

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F 000	Continued From page 2 TSH- Thyroid Stimulating Hormone TV- Television Ug - Microgram	F 000		05/16/2022
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to implement its policy and procedure to investigate injuries of unknown origin for two (2) of four (4) sampled residents (Residents #1 and #2). Findings included... Review of the facility policy titled, "Injury of Unknown Origin" revised 02/2022, documented, "...Immediately a resident is identified with an injury of unknown origin, the facility will ... investigate...interview and/or obtain statements from potential witnesses as determined by the scope of the investigation..." Review of the facility policy titled, "Investigation Process" revised 02/2022, documented, "...The	F 607	F607 **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. 1.The affected Resident #1 and Resident #2 were assessed on 3/1/2022 No new incident or occurrences or injury of unknown observed. Resident #1 and Resident # 2 did not suffer any negative outcome. 2. The facility Staff Development/Designee will provide education to the facility Unit Managers and Supervisors on the importance of conducting interviews and obtaining statement from potential witnesses and during an investigation of injury of unknown that involves the facility residents. The compliance date for this intervention 5/7/22 **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have potential to be affected. 2. The Unit Manager/ Designee will complete house wide review/audit of all injuries of unknown origin to ensure investigation was conducted and potential witnesses are interviewed and statement are obtained weekly times 4, then, monthly times 3 months. 3. Any issue found during this audit will be addressed. The compliance date for this intervention 4/30/2022	

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F 607	Continued From page 3 facility will ensure thorough investigation during an incident or occurrences that may involve our residents...Investigation... interview and/or obtain statements from potential witnesses as determined by the scope of the investigation..." 1. Resident #1 was admitted to the facility on 07/07/2021, with diagnoses that included Rheumatoid Arthritis, Diabetes Mellitus 2, Hypertension, Cerebral Edema, Gastroesophageal Reflux Disease, Hyperlipidemia and Major Depressive Disorder. A review of Resident #1's Quarterly Minimum Data Set (MDS) dated 12/10/2021 revealed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "06" in Section C (Cognitive Patterns), indicating severely impaired cognitive status. On 02/24/2022 at 11:59 AM, the Department of Health received an incident report that documented the following: "...During change of shift round, resident noted with open blister on right hip measuring 3.7cm (centimeter) x 2.84cm x 0.1cm. moderate drainage noted, 100% epithelial. Resident noted with mild pain. Acetaminophen (pain reliever) 650mg administered via g-tube (gastrostomy tube) for mild pain. Right hip cleansed with normal saline, pat dry, and apply Calcium Alginate, and covered with bordered dressing daily. Medicate with Tylenol (pain reliever) 650mg (milligram), 30 minutes prior to wound care. Frequent turn and reposition encouraged. Dietitian and team made aware. RP (representative) made aware. NP (Nurse Practitioner) [name] notified..."	F 607	**Measures to Prevent Recurrence** The facility Staff Development/ Designee will provide an education /In-service to all facility Unit Managers and Supervisors on investigation process. The in-service or education will explain the importance of conducting interviews and obtaining statement from potential witnesses for residents injury of unknown origin. The compliance date for this intervention 5/7/22 **Monitoring Corrective Action:** 1. The Unit Manager/Designee will conduct house wide audit all injuries of unknown origin to ensure the investigation was conducted, and the potential witnesses are interviewed and statement(s) is obtained weekly times 4, then, monthly times 3 months. 2. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022

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F 607	Continued From page 4 A review of the facility's documentation for Resident #1's injuries of unknown origin (pressure sores) incident investigation showed under witnesses "no witnesses found." A review of the staffing report for 02/21/2022 and 02/22/2022 (date of the alleged incident) showed that in addition to the Unit Manager who cared for Resident #1, there were three (3) Certified Nurse Aides (CNA) and three (3) licensed nurses that were assigned to care for Resident #1 for the three shifts (7:00 AM-3:00 PM; 3:00 PM -11:00 PM and 11:00 PM -7:00 AM). A review of the facility's investigation documentation lacked documented evidence of written statements from the 3 CNAs and 3 nurses that cared for Resident #1 the day before the incident and the day of the alleged incident [02/21/2022 and 02/22/2022]. 2. Resident #2 was admitted to the facility on 11/16/2018 with multiple diagnoses that included: Cerebral Vascular Disease, Muscle Weakness, Type 2 Diabetes Mellitus and Hypertension. Review of a facility reported incident dated 01/18/2022 documented, "New Skin Area ...During AM (morning) care, resident observed with open blister on right buttock measuring 6.32 cm x 4.74 cm x 0.1 cm..." A review of the facility's documentation for "new skin area" investigation dated 01/18/2021 showed under witnesses, "no witnesses found." A review of the staffing report for 01/15/2022 to 01/17/2022 (date of the alleged incident) showed	F 607		

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F 607	Continued From page 5 that there were seven (7) different CNA's and eight (8) different licensed nurses that were assigned to and cared for Resident #2 for the three shifts (7:00 AM-3:00 PM; 3:00 PM -11:00 PM and 11:00 PM -7:00 AM). Review of the facility's investigation documentation lacked documented evidence of written statements from the CNAs and licensed nurses that cared for Resident #2 on the day of and the days prior to the incident (01/17/2022). During a face-to-face interview conducted on 03/01/2022 at approximately 11:00 AM with Employee #2 (Director of Nursing), she acknowledged that the facility failed to provide name(s) of witnesses and to obtain written statements from staff who were present during and/or involved in the care of Residents' #1 and #2 when the incidents (injury of unknown origin) occurred.	F 607		05/16/2022
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 4 sampled residents, the facility staff failed to code the Minimum Data Set (MDS) to accurately reflect one (1) resident's risk of pressure ulcers/injuries (Resident #1). Findings included... Resident #1 was admitted to the facility on	F 641	**F641** **Corrective Action for the Residents Affected:** Section M (Skin Conditions), M0150 of the MDS 12/10/2021for Resident #1 was modified on 03/1/2022 to reflect the accurate coding of Risk of Pressure Ulcers/injuries: The affected Resident #1 did not suffer any negative outcome. The Regional Director of MDS will provide education to the facility MDS coordinators on accurate coding of Section M (Skin Conditions), M0150 of the MDS per RAI guidelines. The compliance date for this intervention 5/7/22 **Identification of others with the Potential to be affected:** All residents residing in the facility have potential to be affected.	

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F 641	Continued From page 6 07/07/2021, with diagnoses that included Rheumatoid Arthritis, Diabetes Mellitus 2, Hypertension, Cerebral Edema, Gastroesophageal Reflux Disease, Hyperlipidemias, and Major Depressive Disorder. Review of Resident #1's medical record revealed the following: 07/08/2021 at 10:45 AM [Skin/Wound Note] "... [Resident Name] was observed with...redness to the sacrum and perinea area..." 09/21/2021 [Physician's order] "Calmoseptine ointment Apply to buttocks topically every shift for skin irritation for 4 weeks." 09/22/2021 [Tissue Analytics] "Sacrum L (length) 3.33 cm (centimeter) x W (width) 3.52 cm x 0.1 cm Wound acquired in-house on 9/22/21, new wound, moisture associated skin damage (MASD) epithelialization 100% attach edges scant drainage of serosanguineous, no odor peri-wound intact, ensure compliance with turning protocol wedge/foam cushion for offloading, Barrier cream TID (three times a day) and PRN (as needed)." 11/19/2021 [Physician's order] "Calmoseptine ointment Apply to buttocks topically every shift for skin irritation for 4 weeks." 12/10/2021 [Quarterly MDS], in Section M (Skin Conditions), M0150 Risk of Pressure Ulcers/injuries: "Is the resident at risk of developing pressures/injuries? Facility staff coded "0", indicating, "No Risk of Pressure Ulcers/injuries."	F 641	All residents' records were audited for accurate coding per RAI instructions. Corrections to the MDS were made accordingly. The compliance date for this intervention 03/08/2022. **Measures to Prevent Recurrence** The facility MDS coordinators will be educated/ in-serviced by the Regional Director of MDS on the accurate coding of Section M (Skin Conditions), M0150 of the MDS per RAI guidelines. The compliance date for this intervention 5/7/22 **Monitoring Corrective Action:** MDS coordinators will complete audits to include all OBRA assessments weekly x4 then monthly until compliance achieved. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022

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F 641	Continued From page 7 The evidence showed that the facility staff failed to code the MDS to reflect that Resident #1 is at risk of developing pressures ulcers/injuries. During a face-to-face interview on 03/01/2022, at approximately 1:15 PM with Employee #2 (Director of Nursing), she acknowledged the findings and made no comments.	F 641	F656	05/16/2022
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	**Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. **1.** The affected Resident #2 was re-assessed on 03/01/2022, to ensure that no new in house acquired pressure ulcer/injury developed. No new pressure ulcer/ injury observed. **2** The care plan of .Resident #2 was reviewed and revised by the facility Unit Manager including measureable goals and interventions for the management of a facility acquired pressure ulcer/injury were on 4/12/2022. Resident #2 did not suffer any negative outcome. **3.**The facility Staff Development/Designee will provide education to the facility Unit Managers/ Supervisor on the importance of developing of a relevant care plan that included measureable goals and interventions for the management of a facility acquired pressure ulcer/injury in a timely manner. The compliance date for this intervention 5/7/22 **Identification of others with the Potential to be affected:** **1.** All residents residing in the facility have potential to be affected.	

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F 656	Continued From page 8 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to develop a relevant care plan that included measureable goals and interventions for the management of a facility acquired pressure ulcer/injury in a timely manner for one (1) of four (4) sampled residents (Residents #2). Findings included... Resident #2 was admitted to the facility on 11/16/2018 with multiple diagnoses that included: Cerebral Vascular Disease, Muscle Weakness, Type 2 Diabetes Mellitus and Hypertension. Review of the medical record revealed: 01/17/2022 at 4:01 PM [Nurses Note] "...During routine AM (morning) care, resident was noted to have blisters on the right buttocks area..." Review of the comprehensive care plan revealed that facility staff did not develop a care plan focus area with goals and interventions for Resident	F 656	2.The Unit Manager/ Designee will complete house wide review/audit of all residents with pressure ulcer/ injury and physician treatment orders to identify potential residents that relevant care plan that included measureable goals and interventions are not are developed in a timely manner for the management of a facility acquired pressure ulcer/injury weekly times 4, then, monthly times 3 months. 3. Any issue found during this audit will be addressed. The compliance date for this intervention 4/30/22 **Measures to Prevent Recurrence** The facility Staff Development/ Designee will provide an education/ In-service to all facility Unit Managers/ Supervisors. The in-service or education will explain the importance of developing a relevant care plan that included measureable goals and interventions for the management of a facility acquired pressure ulcer/injury in a timely manner. The compliance date for this intervention 5/7/22 **Monitoring Corrective Action** 1.The Unit Manager/ Designee will conduct house wide audit of all residents with pressure ulcer/ injury and physician treatment orders to identify potential residents that relevant care plan that included measureable goals and interventions are not developed in a timely manner for the management of a facility acquired pressure ulcer/injury weekly times 4, then, monthly times 3 months. 2. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022

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F 656	Continued From page 9 #2's right buttocks area until 02/08/2022, 22 days after the pressure ulcer/injury was initially observed. During a face-to-face interview conducted on 03/01/2022 at 1:30 PM, Employee #4 (1st floor Unit Manager) acknowledged the finding and stated, "The care plan was implemented on 02/08/2022 and revised on 02/28/2022."	F 656		05/16/2022
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657	**F657** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The Resident#1 in house acquired sacral wound resolved on 4/5/2022 1. The affected Resident #1 was re-assessed on 03/01/2022, to ensure that no new facility acquired pressure ulcer/injury developed. No new pressure ulcer/ injury observed. 2. The comprehensive care plan of Resident #1 was revised and updated with goals and interventions to address resident's needs on 04/21/22. Resident #1 did not suffer any negative outcome. 3.The facility Staff Development/Designee will provide education to the facility Unit Managers/ Supervisor. The education will explain the importance of revising and updating resident comprehensive care plan with goal and approached to address resident's risk for pressure ulcers/injuries, and revising the focus area with goals and interventions to address Resident #1's in-house acquired pressure ulcers/injuries. The compliance date for this intervention 05/7/22.	

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F 657	Continued From page 10 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of four (4) sampled residents, the facility staff failed to update the comprehensive care plan with goals and approaches to address one (1) resident's risk of pressure ulcers/injuries (Resident #1). Findings included... Record review of the facility policy titled, "Interdisciplinary Team Meeting (Care Planning Meeting)" revised 02/2022 documented, "...the care plan will be reviewed and revised by the interdisciplinary team after each assessment..." Resident #1 was admitted to the facility on 07/07/2021, with diagnoses that included Rheumatoid Arthritis, Diabetes Mellitus 2, Hypertension, Cerebral Edema, Gastroesophageal Reflux Disease, Hyperlipidemias, and Major Depressive Disorder. Review of the "Tissue Analytics" reports for Resident #1 revealed: "Sacrum L (length) 3.33 cm (centimeter) x W (width) 3.52 cm x 0.1 cm Wound acquired in-house on 9/22/21, new wound, moisture associated skin damage (MASD) epithelialization 100% attach edges scant drainage of serosanguineous, no odor peri-wound intact, ensure compliance with turning protocol wedge/foam cushion for offloading, Barrier cream TID (three times a day) and PRN (as needed)." A review of Resident #1's comprehensive care	F 657	**Identification of others with the Potential to be affected:** 1. All residents residing in the facility have potential to be affected. 2.The Unit Manager/ Designee will complete house wide review/audit of all residents with potential risk for pressure ulcer/ injury; that the facility staff failed to update their comprehensive care plan with goals and approaches to address resident's risk of pressure ulcers/injuries weekly times 4, then, monthly times 3 months 3. Any issue found during this audit will be addressed. The compliance date for this intervention 4/30/22 **Measures to Prevent Recurrence** The facility Staff Development/ Designee will provide an education/ In-service to all facility Unit Managers/Supervisors. The in-service or education will explain the importance of revising and updating resident comprehensive care plan with goal and approached to address resident's risk for pressure ulcers/injuries, and revising the focus area with goals and interventions to address Residents' in-house acquired pressure ulcers/injuries. The compliance date for this intervention 5/7/22 **Monitoring Corrective Action** 1. The Unit Manager/ Designee will conduct house wide audit of all residents with potential risk for pressure ulcer/ injury that the facility staff failed to update their comprehensive care plan with goals and approaches to address resident's risk of pressure ulcers/injuries weekly times 4, then, monthly times 3 months.	05/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 03/01/2022

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F 657	Continued From page 11 plan showed a focus area, "[Resident Name] actual impairment to skin integrity ..." was initiated on 07/08/2021 with goals and interventions. Continued review revealed that facility staff failed to revise this focus area with goals and interventions to address Resident #1's in-house acquired sacral wound on 09/22/2021. During a face-to-face interview conducted on 03/01/2022, at approximately 1:15 PM with Employee #2 (Director of Nursing), she acknowledged the findings.	F 657	2. The Unit Manager/ Designee will conduct house wide audit of all residents with pressure ulcer/Injury to identify potential residents that facility staff failed to revise care plans focus area with goals and interventions to address the pressure ulcer/ Injury weekly times 4 then, monthly times 3 months. 3. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of four (4) sampled residents, the facility's staff failed to provide Resident #2 with services consistent with the professional standards of practice as evidenced by failure to document the progressive worsening of a right buttocks pressure ulcer/injury.	F 686	F686 **Corrective Action for the Residents Affected:** The affected Resident #2 was re-assessed on 3/1/22, Resident #2 Pressure ulcer/unstageable on right buttock and pressure ulcer/suspected DTI on left heel were stable. Resident # 2 did not suffer any negative outcome. The facility Staff Development/Designee will provide education to the facility licensed nurses The education will explain the importance of documenting on the progressive worsening of the Resident # 2 wound. The compliance date for this intervention 5/7/22 **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 12 Findings included... Review of the facility policy titled, "Nursing Assessment", revised 01/2022, "... Skin: as you examine all body systems you need to make note of the status of the Integumentary System for any breaks in the skin, scars, lesions, wounds, redness or irritation. Assess the turgor, color, temperature and moisture of the skin..." Resident #2 was admitted to the facility on 11/16/2018 with multiple diagnoses that included: Type 2 Diabetes Mellitus, Cerebral Vascular Disease, Muscle Weakness and Hypertension. Review of Resident #2's medical record revealed the following: 06/24/2020 [current Physician's Order] "Weekly skin assessment by licensed nurse. Document and notify MD (medical doctor)/NP (Nurse Practitioner) for abnormal findings every day shift every Wed (Wednesday)" 10/04/2021 at 2:19 PM [Weekly Skin Assessment- Licensed Nurse] "...no pressure ulcer...skin intact..." Review of Resident #2's care plan with a revision date of 10/27/2021 revealed the following: - [Resident Name] has air mattress for pressure relief/weight distribution revised had the intervention ..."2 person assist for ADL (activities of daily living)..." - [Resident Name] has altered peripheral tissue perfusion, Peripheral Vascular Disease (PVD) and DVT (Deep Vein Thrombosis) had the	F 686	2.The Unit Manager/ Designee will complete house wide review/audit of all residents with pressure ulcer/ injury to identify the potential resident that the facility licensed nurse failed to document the progressive worsening of the wound. Any issue found during this audit will be addressed The compliance date for this intervention 04/30/22 **Measures to Prevent Recurrence** The facility Staff Development/ Designee will provide an education/ In-service to all facility Licensed Nurses. The education will explain the importance of documenting on the progressive worsening of the residents' wound. The compliance date for this intervention 5/722 **Monitoring Corrective Action** 1.The Unit Manager/ Designee will conduct house wide audit of all residents with pressure ulcer/ injury to identify potential resident that the facility licensed nurse failed to document the progressive worsening of the wound. to weekly times 4, then, monthly times 3 months. 2.. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 13	F 686		

following interventions,
"...Monitor/document/report to MD PRN (as needed) any s/sx of skin problems related to PVD: redness, edema, blistering ...other skin lesions ..."
Care plan revised on 10/27/2021 - [Resident Name] has altered bowel elimination, bowel incontinence r/t muscle weakness, stroke, had the following intervention, "...Check resident every two hours and assist with toileting as needed..."

- [Resident Name] has an ADL self care performance deficit r/t muscle weakness, lack of coordination revised on 10/27/2021 had the following interventions, "[Resident Name] is totally dependent on staff to provide a bath and as necessary... totally dependent on staff for repositioning and turning in bed..."

- [Resident Name] at risk for alteration in skin integrity related to fragile skin (wearing face mask), had the following interventions, "... Barrier cream to peri area/buttocks q shift and prn ... observe for signs and symptoms of decreased circulation/skin impairment Report changes as needed, observe skin condition with ADL care daily; report abnormalities..."

According to the 01/04/2022 Quarterly Minimum Data Set (MDS) Assessment, facility staff coded Resident #2 as cognitively impaired, functionally dependent for mobility and ADL care and incontinent of bowel and bladder.

In Section M (Skin Conditions) the following was noted:

M0150. Risk of Pressure Ulcers/Injuries - Is this resident at risk of developing pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 14 ulcers/injuries? "yes" M0210. Unhealed Pressure Ulcers/Injuries - Does this resident have one or more unhealed pressure ulcers/injuries? "yes" M1040. Other Ulcers, Wounds and Skin Problems, "None of the above" M1200. Skin and Ulcer/Injury Treatments - Pressure reducing device for bed, "yes" Application of nonsurgical dressings (with or without topical medications) other than to feet "Yes" Applications of ointments/medications other than to feet, "Yes" 01/16/2022 at 6:47 AM [Braden Scale for Predicting Pressure Ulcers] - "...Category: High risk Score: 12.0..." 01/17/2022 at 12:54 PM [Situation Background Assessment Response (SBAR)] - "...During AM (morning) care, resident observed with open blister to right buttocks area..." 01/17/2022 at 4:01 PM [Nurses Note] - "During routine AM (morning) care, resident was noted to have blisters on the right buttocks area. Order obtained from [Nurse Practitioner's Name] to clean with normal saline solutions, pat dry and apply Xeroform, cover with dry dressing daily and PRN until reviewed by the wound team. Resident will be turned and repositioned every 2 hours for pressure relief including frequent incontinent care..."	F 686		

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F 686	Continued From page 15 01/18/2022 at 10:24 AM [Tissue Analytics] - "... wound location right buttock ... length 6.32 cm, width 4.74 cm... maximum depth 0.1 cm ... black tissue 0.01 cm... % (percent) granulation 100, wound status bullae now deroofed [per Employee #5 (Wound NP), deroofed means to remove the thin layer from a blister]...dressings silver alginate". 01/19/2022 [Physician's Orders] "Clean open blister on the left buttocks with Normal Saline solution, pat dry, apply Xeroform (fine mesh gauze occlusive dressing impregnated with petrolatum) and cover with dry dressing daily and PRN (as needed) until reviewed by the wound team" D/C (discontinue) date 01/19/2022. 01/20/2022 [Physician's Orders] "Cleanse right buttock bullae with normal saline pat dry apply silver alginate [antimicrobial silver alginate dressing] and cover with bordered gauze daily every day shift" D/C date 01/26/2022." 01/21/2022 at 3:45 AM [Nurses Note] - "... Incontinent care, turning and repositioning in progress q (every) 2 hours..." 01/23/2022 at 6:29 AM (Braden Scale for Predicting Pressure Ulcers) "... Category: High risk Score: 12.0..." 01/25/2022 at 6:45 AM [Nurses Note] - "... Remain total depended on 2 staff [for] adl care with incontinent care, turning and repositioning q 2 hours provided..." 01/25/2022 at 10:02 AM [Tissue Analytics] - "... wound location right buttock ... length 5.65 cm, width 5.67 cm ... maximum depth 0.1 cm ... black	F 686		

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F 686	Continued From page 16 tissue 1.49 cm... % (percent) granulation 30.00, % slough/eschar 70.00, wound status bullae now deroofed (on 01/18/2022) ...dressing Medihoney" TAR for 01/2022 revealed that the facility's licensed staff initialed in the area, "Cleanse right buttock bullae with normal saline pat dry apply silver alginate [antimicrobial silver alginate dressing] and cover with bordered gauze daily every day shift" on dates 01/21/2022, 01/22/2022, 01/23/2022 and 01/24/2022, indicating that the task was completed. It should be noted that from 01/19/2022 through 01/24/2022 (6 days), there was no documented evidence that a licensed nurses who performed the daily wound treatment, assessed or noted that Resident #2's wound worsened during this time. Subsequently, on 01/25/2022, Resident #2's right buttocks wound was noted to have deteriorated from 100% granulation on 01/18/2022 to 30% granulation and 70% slough/eschar on 01/25/2022. 01/27/2022 [Physician's Order] "Cleanse right buttock bullae with normal saline pat dry apply Medihoney (draws fluid from deeper tissues to the wound surface to promote removal of devitalized tissue] and cover with bordered gauze daily every day shift" D/C date 02/08/2022 02/01/2022 at 10:21 AM [Tissue Analytics] "... wound location right buttock ... length 5.64 cm, width 6.33 cm ... depth 0.10 cm ... black tissue 7.19 cm... % granulation 30.00, % slough/eschar 70.00 ... bullae now deroofed (on 01/18/2022) ... wound status stable ...dressing Medihoney" 02/04/2022 at 10:27 PM [Nurses Note] "... During	F 686		

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F 686	Continued From page 17 wound care, it was observed a foul odor with drainage ... [Physician's Name] were notified, wound assessment done by [NP's Name] and was diagnosed with wound infection..." 02/05/2022 [Physician's Order] "Doxycycline (antibiotic) ... 100 mg capsule ...give 1 capsule via G- tube two times a day for wound infection" 02/08/2022 at 10:16 AM [Tissue Analytics] "... wound location right buttock ... length 5.25 cm width 8.17 cm.. depth 6.00 cm ... black tissue 10.56 cm ... previously classified as bullae ...wound status worsening ... pressure ulcer - unstageable ...dressing Dakins moist to dry..." 02/08/2022 at 10:24 AM [Skin/Wound Note] "...procedures ulcer debridement (surgical removal of damaged tissue from a wound) site 1... right buttock... percent debrided 100%..." 02/08/2022 at 3:06 PM [Nurses Note] "The writer f/u (follow-up) with the [Representative's Name] to inform him that the debridement was done by the wound team..." 02/08/2022 [Physician's Orders] "Cleanse right buttock unstageable pressure ulcer with Dakin's solution [antiseptic solution to treat infected wounds] two times a day and pat with Dakins gauze every day and evening shift" 02/08/2022 [Physician's Order] "Dakins (full strength) Solution 0.5 % (Sodium Hypochlorite) Apply to Right buttock topically every day and evening shift for wound" Care plan created on 02/08/2022 - "[Resident Name] has pressure ulcer development right	F 686		

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F 686	Continued From page 18	F 686		

buttock unstageable pressure ulcer, previously classified as bullae/blister." Interventions, "Nurses must monitor dressing every shift to ensure it is intact and adhering, the resident needs assistance) to turn/reposition at least every 2 hours ... assess/record/monitor wound healing weekly. Measure length, width and depth where possible ... Report improvements and declines to the MD ... Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage... [SIC]"

A wound care observation was conducted on 02/28/2022 at 11:58 AM of Resident #2 with Employee #12 (Licensed Practical Nurse/Wound Nurse). Resident #2 was pre-medicated for pain. There were no breaks in infection control during the wound dressing change. A wound on the right buttocks area, about the size of an orange (approximately 6 centimeters), was observed to be deep, red and with a small amount of drainage. The surrounding tissue was pink. The wound was cleaned with Dakin's [antiseptic solution to treat infected wounds] solution and dressed with Dakin's wet to dry. Skin prep was applied to the left heel, where a blackened area about the size of a kiwi fruit (approximately 4 centimeters) was noted.

Further review of Resident #2's medical record noted the following:

02/10/2022 at 1:11 PM [Nutrition Note] "...Pressure ulcer/unstageable on right buttock ... pressure ulcer/suspected DTI on left heel ... resident is already on 30 ml Prostat sugar free protein supplement ...Vitamin C 500 mg and [Zinc] to support healing. Added 1 pkt (packet)

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F 686	Continued From page 19 Juven ... Resident continues to receive 40 mg protein from tube feeding..." 02/10/2022 at 10:21 PM [Nurses Note] "Resident... transfer from unit 3 to unit 1 room 136b..." Care plan revised on 02/10/2022 - [Resident Name] is at nutritional risk r/t multiple diagnoses ..., had the following interventions, " ... Enteral Feed Order: Jevity 1.5 cal (calories) at 35 mL (milliliters)/hr (hour) x 18 hrs via G (Gastrostomy)-Tube to provide (630 ml/945 kcal (kilocalories), 40 gm (gram) protein ...Supplement order: 30 ml Prostat (protein supplement) sugar free 2x/day, 1 pkt Juven (therapeutic nutrition powder) 2x/day for protein supplement/wound healing ..." 02/12/2022 [Physician's Order] "Wound care consult at [Hospital's Name] wound clinic. R (right) Buttock ulcer..." 02/14/2022 [Laboratory's Name]: HBA1c (hemoglobin A1C) - 6.0% [Reference Range 4.8-5.6] Albumin - 3.6 g/dL (grams per deciliter) [Reference Range 3.5-5.5] Total protein- 6.5 g/dL [Reference Range 6.3-8.0] During a face-to-face interview conducted on 03/01/2022 at 12:40 PM, Employee #5 (Wound Nurse Practitioner) was asked about Resident #2's right buttocks wound. She stated, "Blisters can develop overnight, within hours. Blisters can lead to pressure injury. When asked if slough/eschar should have been noticed on Resident #2's right buttock wound before it got to 70%, Employee #5 stated, "It's hard to predict what the nurses should have noticed but yes	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 20	F 686		

that's something noticeable and should have been documented. I'm at the facility every Tuesday and that's the day I do my rounds (includes wound observation, measurements and writing recommendations for treatment/interventions). It's hard to say if it was unavoidable. Antibiotics were started and Dakin's wet to dry dressings. The slough came off and the wound is clean, no infection. I recommended a wound vac as most ideal right now to get the wound closed. The resident's family wanted an outside opinion so she (Resident #2) has a wound consult scheduled for 03/04/2022. The wound vac will be applied after that appointment."

A face-to-face interview was conducted on 03/01/2022 with Employee #6 (Licensed Practical Nurse) at 3:14 PM, who was assigned to Resident #2 on 01/22/2022. According to the TAR, Employee #6 signed off to completing the wound dressing change on Resident #2 on 01/22/2022 (Saturday). Employee #6 stated, "I documented that the wound [care] was done. I always a write an assessment [progress] note on residents who have G-tubes or wounds. It must've been an oversight. We have a lot of visitors on the weekends but that's not an excuse to not write a note."

During a face-to-face interview conducted on 03/01/2022 at 3:45 PM with Employee #2 (Director of Nursing), she asked if licensed nurses are required to write a progress note or do an assessment on every resident every day. Employee #2 stated, "Nurses don't document every day on every resident. There is mandatory assessment and documentation every shift for residents on antibiotics, IVs (intravenous), G-tube, isolation, new admissions, wounds,

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	095015	A. BUILDING _____ B. WING _____	C 03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21	F 686		

infections and skilled care services." When asked if there is policy that states that, Employee #2 stated, "No. This is communicated to the nurses during huddles." Employee #2 was then asked how the facility is making sure those residents who require mandatory assessments/progress notes are being documented on. The Employee stated, "The documentation is checked during clinical meetings that are done every morning. But this has lapsed due to COVID-19." It was brought to Employee #2's attention that from 01/19/2022 through 01/24/2022 (6 days), there was no documented evidence that the licensed nurses who performed the daily wound treatment on Resident #2 assessed or documented that Resident #2's wound worsened during this time. Employee #2 acknowledged the finding and stated, "I will look into it."

A face-to-face interview was conducted on 03/01/2022 with Employee #7 (Registered Nurse), at 4:03 PM. Employee #7 was assigned to Resident #2 on 01/21/2022 (Friday) and 01/23/2022 (Sunday). The TAR revealed that the Employee signed off to indicate that she completed the wound dressing on those days. Employee #7 was asked what would be something that she would report to the doctor if observed during a dressing change, she stated, "Odor, increase drainage, redness and pain." When asked if she did the dressings for Resident #2 on 01/21/2022 and 01/23/2022, Employee #7 stated, "Yes. The nurse assigned does the dressing changes when the wound nurse doesn't do it. When asked about if she was aware of the residents that the facility requires mandatory progress notes and assessments on every shift, Employee #7 stated, "Yes. Residents who have feeding tubes, wounds, infections, on quarantine."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 03/01/2022

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F 686	Continued From page 22 Employee #7 was then asked why she failed to document an assessment/progress note on Resident #2 on those two days she was assigned, she stated, "I think I just missed doing her [Resident #2] documentation." The evidence showed that after Resident #2's right buttock blister/bullae deroofed on 01/18/2022, the facility's licensed staff who conducted the daily wound care treatments failed to document the progressive worsening of the wound (increase of slough/eschar) for a period of six (6) days (01/19/2022 to 01/25/2022).	F 686		05/16/2022
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to ensure that two (2) of four (4) sampled residents received proper treatment and care to maintain good foot health (Residents #1 and #2). Findings included...	F 687	**F687** **Corrective Action for the Residents Affected:** The affected Resident #1 and Resident #2 were assessed on 03/01/2022. Resident #1 was seen by Podiatrist on 3/2/2022. Resident #2 was seen by Podiatrist on 3/8/2022 Resident # 1 and Resident #2 did not suffer any negative outcome. The facility Staff Development/Designee will provide education to the to facility Licensed Nurses, the facility Certified Nursing Assistants (CNAs), and the facility Temporary Nurse Aides. The education will explain the importance of ensuring residents received proper treatment and care to maintain good foot health and providing Podiatry access to the residents, who has diagnoses that poses risks for foot health. The compliance date for this intervention 5/7/22	

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F 687	Continued From page 23 Record review of the facility policy titled, "Activity of Daily Living (ADL) revised 01/2022, documented, " ...Activities of daily living are provided by our CNAs (Certified Nurse Aides), LPNs (Licenses Practical Nurse), RNs (Registered Nurse), Restorative Care, and Rehab Staff ...Activities of daily living includes: bathing, showers ... grooming..." According to the Center for Disease Control (CDC) "...Diabetes can reduce the amount of blood flow to your feet. Numbness and less blood flow can slow the time it takes for sores to heal and lead to foot problems...You should have a podiatrist check your feet once a year or more..." https://www.cdc.gov/diabetes/pdfs/library/Diabetes-Feet-h.pdf 1. Resident #1 was admitted to the facility on 07/07/2021, with diagnoses that included Diabetes Mellitus 2, Rheumatoid Arthritis, Hypertension, Cerebral Edema, Gastroesophageal Reflux Disease, Hyperlipidemias, and Major Depressive Disorder. During an observation on 02/28/2022 at 10:30 AM, Resident #1 was noted to be sitting up in her bed with both feet and hands partially exposed. During this time, Resident #1 was observed with elongated toenails. Resident #1was asked has she seen a podiatrist, she responded, "Not this year." Review of Resident #1s medical record revealed: 11/18/2021 [Physician's order] "Podiatry eval and treat as needed"	F 687	**Identification of others with the Potential to be affected:** 1. All residents residing in the facility have potential to be affected. 2. The Unit Manager/ Designee will complete house wide review/audit of all facility residents' feet including those with diagnosis that pose risk for foot health to identify potential residents that the facility nursing staff failed to provide access for proper treatment and care to maintain good foot health. .Any issue found during this audit will be addressed. The compliance date for this intervention 4/30/22 **Measures to Prevent Recurrence** The facility Staff Development/ Designee will provide an education/ In-service to facility Licensed Nurses, the facility Certified Nursing Assistants (CNAs), and the facility Temporary Nurse Aides. The education will explain the importance of ensuring residents received proper treatment and care to maintain good foot health and providing Podiatry access to the residents, who has diagnoses that poses risks for foot health. The compliance date for this intervention 5/7/22 **Monitoring Corrective Action** 1.The Unit Manager/ Designee will conduct house wide audit all residents feet including those with diagnosis that pose risk for foot health to identify potential residents that the facility nursing staff failed to provide access for proper treatment and care to maintain good foot health weekly times 4, then, monthly times 3 months. 2.. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee	05/16/2022

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F 687	Continued From page 24 11/19/2021 A "Podiatry Consultation" documentation sheet indicating this was the last date Resident #1 was seen by the podiatrist. During a face-to-face interview on 02/28/2021 at 10:00 AM, with Employee #11 (Certified Nurse Aide) stated, "[Resident name] is a diabetic, we do not cut her nails, the podiatrist comes to do them." The evidence showed that facility staff failed to ensure Resident #1 was provided access to the podiatrist to provide services to maintain good foot health. During a face-to-face interview conducted on 02/28/2022 at 10:34 AM, Employee #13 (Unit Secretary) stated, "The podiatrist comes in almost every day. The nurses fill out a consult sheet and put it in the podiatrist's folder for the resident to get seen." During a face-to-face interview on 03/01/2021 at 12:00 PM, Employee #10 (Registered Nurse) acknowledged the finding. 2. Resident #2 was admitted to the facility on 11/16/2018 with multiple diagnoses that included: Type 2 Diabetes Mellitus, Cerebral Vascular Disease, Muscle Weakness and Hypertension. Review of Resident #2's medical record revealed the following: 06/17/2020 [Physician's Order] "Podiatry eval (evaluation) and treat as needed" 06/24/2020 [Physician's Orders] "Weekly skin assessment by licensed nurse. Document and	F 687		

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F 687	Continued From page 25 notify MD (medical doctor)/NP (Nurse Practitioner) for abnormal findings every day shift every Wed (Wednesday)" 10/27/2021 [Care Plan] Focus area: "[Resident Name] has altered peripheral tissue perfusion, Peripheral Vascular Disease and DVT (Deep Vein Thrombosis)." Intervention(s): "...Elevate legs when sitting or sleeping ...If resident has thick nails, corns, calluses, refer to podiatrist..." 10/27/2021 [Care Plan] Focus area: "[Resident Name] has an ADL (activities of daily living) self care performance deficit r/t (related to) muscle weakness, lack of coordination." Intervention(s): "[Resident Name] is totally dependent on staff to provide a bath and as necessary..." 01/04/20222 [Quarterly Minimum Data Set (MDS)] facility staff coded the following: In Section G (Functional Status): G0110. Activities of Daily Living (ADL) Assistance - personal hygiene, "Total dependence" and "two+ (plus) physical assist" In Section I (Active Diagnoses), "Peripheral Vascular Disease..." In Section M (Skin Conditions): Application of nonsurgical dressings (with or without topical medications) other than to feet, "Yes" Applications of ointments/medications other than to feet, "Yes" Review of Resident #2's electronic and paper	F 687		

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F 687	Continued From page 26 health record revealed that the resident had a podiatry consult visit on 10/08/2019 and did not receive another consult visit until 02/23/2022 (2 years and 4 months). Facility staff failed to ensure that Resident #2, who has diagnoses that poses risks for foot health (Type 2 Diabetes Mellitus and PVD), received the proper treatment and care to maintain good foot health. During a face-to-face interview conducted on 03/01/2022 at 1:30 PM with Employee #4 (1st floor Unit Manager), she acknowledged the finding and stated that the weekly skin assessment does include nail care and that the staff [licensed nurses and CNAs] should report when they see a resident needs a podiatrist, especially the diabetic residents.	F 687		05/16/2022
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688	**F688** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The affected Resident #2 re- assessed on 03/01/2022. Resident #2 currently on Occupation Therapy started 04/19/22 Resident #2 did not suffer any negative outcome The facility Staff Development/Designee will provide education to the facility nursing staff The education will explain the importance of ensuring that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion. The compliance date for this intervention 5/7/22 **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have potential to be affected.	

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F 688	Continued From page 27 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to ensure one (1) of four (4) sampled residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion (Resident #2). Findings included... Record review of the facility policy titled, "Restorative Nursing Care" revised 02/2022 documented, "...Nursing personnel are trained in restorative nursing care. Restorative nursing care is performed for those residents who require such service...maintaining good body alignment and proper positioning, encouraging and assisting bedfast residents to change positions at least every two hours...assisting residents with their routing range of motion exercises..." Resident #2 was admitted to the facility on 11/16/2018 with multiple diagnoses that included: Muscle Weakness, Cerebral Vascular Disease, Type 2 Diabetes Mellitus and Hypertension. Review of Resident #2's medical record revealed the following: 01/04/20222 [Quarterly Minimum Data Set (MDS)] facility staff coded the following: In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "99", indicating the resident was unable to complete the interview.	F 688	**2.** The facility ADON/Designee will complete house wide review/audit of all facility residents to identify potential residents with limited range of motion that the facility's staff failed to ensure that the residents received appropriate treatment and services to prevent further decrease in range of motion. Any issue found during this audit will be addressed The compliance date for this intervention 4/30/22 **Measures to Prevent Recurrence** The facility Staff Development/ Designee will provide an education/ In-service to facility nursing staff. The education will explain the importance of ensuring that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion. The compliance date for this intervention 5/7/22 **Monitoring Corrective Action** **1.**The ADON/ Designee will The facility ADON/Designee will complete house wide review/audit of all facility residents to identify potential residents with limited range of motion that the facility's staff failed to ensure received appropriate treatment and services to prevent further decrease in range of motion weekly times 4, then, monthly times 3 months. **2.**. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022

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F 688	Continued From page 28 In Section G (Functional Status): G0110. Activities of Daily Living (ADL) Assistance- bed mobility, transfer, toilet use, personal hygiene, "Total dependence" and "two+ (plus) physical assist" G0400. Functional Limitation in Range of Motion - "impairment on both sides" for upper and lower extremities In Section I (Active Diagnoses), "Peripheral Vascular Disease...Osteoarthritis" In Section O (Special Treatments, Procedures, and Programs): O0500. Restorative Nursing Programs - record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily) - facility staff documented "0" for all the sections. 01/19/2022 at 10:46 PM [Restorative Program Nursing Assessment] "...Resident on Restorative Nursing for PROM (passive range of motion) to bilateral extremities...for splinting to right palmar guard; right resting hand splint for 6-8 hours to prevent right hand contractures..." 01/20/2022 9:44 AM [Occupational Discharge Summary] "...Dates of service 12/25/2021-1/19/2022 ...discharge recommendations: RNP (restorative nursing program), R (right) resting hand splint, elevate RUE (right upper extremity) to facilitate tone, reduce risk for shoulder subluxation, contracture..."	F 688		

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F 688	Continued From page 29 Review of the restorative aide documentation for Resident #2 from 01/01/2022 through 02/28/2022 revealed that for 33 out of the 42 restorative days, facility staff documented, "NA (not applicable)" for the restorative task, "... active range of motion exercises of bilateral lower extremities..." During a face-to-face interview conducted on 03/01/2021 at 12:30 PM, Employee #8 (1st floor Restorative Aide) was asked what does it mean when "NA" is documented for a restorative task. Employee #9 explained, "NA means the task was not done for the day. Sometimes we just can't get to it [restorative nursing care tasks]. This evidence showed that the facility's staff failed provide Resident #2 with the appropriate treatment and services to prevent further decrease in range of motion.	F 688		05/16/2022
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	F 842	**F 842** **Corrective Action for the resident Affected:** The Facility can not retroactively correct this deficiency. 1. The affected residents, #1, 2, #3, #4 were reassessed on 3/01/2022. Resident #1, #2, #3, #4, did not suffer any negative outcome . 2. The facility Regional Director of Operation/Designee will provide education to the facility Administrator on the importance of providing the survey team with full access to residents Electronic Health Record (EHR) including TASK.	

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F 842	Continued From page 30 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842	3. The facility Staff Development/Designee will provide education to the facility licensed nurses on the importance of documenting the monthly restorative progress note, according to the resident's plan of care. The compliance date for this intervention 5/7/22 **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have potential to be affected. 2. The Facility Administrator/Designee will complete a house wide audit to identify potential residents that facility staff failed to provide survey team survey team with full access to residents Electronic Health Record (EHR) including TASK. 3. The facility ADON/Designee will conduct house wide audit to identify potential residents that facility staff failed to document the monthly restorative nursing progress note according to the resident plan of care. 4. Any issue found during this audit will be addressed The compliance date for this intervention 4/30/22 **Measures to Prevent Recurrence** 1.The facility Regional Director of Operation/Designee will provide education to the facility Administrator on the importance of providing the survey team with full access to residents Electronic Health Record (EHR) including TASK. The compliance date for this intervention 5/7/22	05/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 31 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to document a monthly restorative nursing progress note for two (2) residents (Residents #1 and #2) and impeded the survey process by not providing full access to four (4) of four (4) resident's electronic health records (EHR) (Residents #1, #2, #3 and #4). Findings included... Record review of the facility policy titled, "Restorative Nursing Care" revised 02/2022 documented, "...There will be a monthly summary note for each resident that are on Restorative Nursing Program and all summaries will be documented in PCC (Point Click Care- the facility's electronic health record system). 1. Facility staff failed to document a monthly restorative nursing progress note for Residents' #1 and #2. A. Resident #1 was admitted to the facility on 07/07/2021, with diagnoses that included Rheumatoid Arthritis, Diabetes Mellitus 2, Hypertension, Cerebral Edema,	F 842	2. The facility Staff Development/Designee will provide education to the facility licensed nurses on the importance of documenting the monthly restorative progress note, according to the resident plan of care. The compliance date for this intervention 5/7/22 **Monitoring Corrective Action** 1.The Facility Administrator/Designee will complete a house wide audit to ensure to identify potential residents that facility staff failed to provide survey team with full access to residents Electronic Health Record (EHR) including TASK, weekly times 4, then, monthly times 3 months. 2.The facility ADON/Designee will conduct house wide audit to identify potential resident that facility staff failed to document a monthly restorative nursing progress note weekly times 4, then, monthly times 3 months. 3. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022

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F 842	Continued From page 32 Gastroesophageal Reflux Disease, Hyperlipidemias, and Major Depressive Disorder. A review of the physician's order showed the following directives and the order date: "11/18/2021 Restorative eval and treat as needed" Review of Resident #1's electronic and paper health record showed that the restorative staff failed to complete a monthly summary note for November 2021, January 2022 and February 2022. B. Resident #2 was admitted to the facility on 11/16/2018 with multiple diagnoses that included: Muscle Weakness, Cerebral Vascular Disease, Type 2 Diabetes Mellitus and Hypertension. Review of Resident #2's electronic and paper health record lacked documented evidence that a monthly restorative summary note was completed for the month of February 2022. During a face-to-face interview conducted on 03/01/2022 at 9:43 AM with Employee #9 (Assistant Director of Nursing /Restorative Program Manager), he acknowledged the findings for Resident #1 and #2 and stated, "The monthly restorative summary notes are done by the licensed staff." 2. Facility staff failed to provide the survey team with full access to Residents' #1, #2, #3 and #4's EHR. During a complaint survey conducted from 02/28/2022 to 03/01/2022, the surveyor team was	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 03/01/2022

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F 842	Continued From page 33 unable to access the "Task" section of the EHR for Residents' #1, #2, #3 and #4. The "Task" secion stores the daily documentation of care completed by the Certified Nurse Aides. During a face-to-face interview conducted on 03/01/2022 at approximately 9:00 AM with Employee #1 (Administrator) she stated, "I've reached out to the person who gives access and they said full access has been granted. There's nothing more to be done."	F 842		05/16/2022
F 917 SS=D	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3) §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and	F 917	**F917** **Corrective Action for the resident Affected:** 1. The affected residents, #4 reassessed on 3/01/2022. The mattress was reset on 3/1/2022 to resident #4 weight range to ensure correct functional setting to meet the need of the resident. Resident #4, did not suffer any negative outcome. 2.The facility Maintenance Director/Designee will provide education to the facility Licensed Nurses, the facility Certified Nursing Assistants (CNAs), and the facility Temporary Nurse Aides on the importance of ensuring that the air mattress is in the correct functional setting to meet one resident's needs The compliance date for this intervention 5/7//22 **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have potential to be affected.	

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F 917	Continued From page 34 (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's staff failed to ensure that the mattress was in the correct functional setting to meet one (1) of four (4) sampled resident's needs (Resident #4). Findings included: Resident #4 was admitted to the facility on 03/22/2019 with multiple diagnoses that included Acute and Chronic Respiratory Failure, Osteoarthritis, Cognitive Communication Deficit and Chronic Pain. Review of Resident #4's medical record revealed the following a physician's order for "weight monthly" dated 7/08/2020. The medical record also noted a 2/15/2022 weight for Resident #4 as "116.7 Lbs Bed Scale". During an observation on 02/28/2022 at 10:01 AM, Resident #4 was noted in bed sleeping. The "Comfort Zone Alternating Pressure with Low Air Loss" mattress was observed to be at the setting, "400 lbs (pounds) 10 firm." During a face-to-face interview conducted on 03/01/2022 1:30 PM with Employee #4 (1st Floor Unit Manager), she acknowledged that Resident #4's mattress setting was not in the correct functional setting and stated, "I am not sure when the company was last came in. They are the ones who come in and adjust the settings on the mattress. I will ask."	F 917	2.The facility ADON/Designee will complete a house wide audit to identify potential residents on air mattress that facility staff failed to ensure that the mattress is in the correct functional setting to meet the needs of the residents. Any issue found during this audit will be addressed. The compliance date for this intervention 4/30/22 **Measures to Prevent Recurrence** The facility Maintenance Director/Designee will provide education to the facility Licensed Nurses, the facility Certified Nursing Assistants (CNAs), and the facility Temporary Nurse Aides on the importance of ensuring that the air mattress is in the correct functional setting to meet one resident's needs The compliance date for this intervention 5/7/2022 **Monitoring Corrective Action** The facility ADON/Designee will complete a house wide audit to identify potential residents on air mattress that facility staff failed to ensure that the mattress is in the correct functional setting to meet the needs of the residents, weekly times 4, then, monthly times 3 months. 3. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	05/16/2022

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F 917	Continued From page 35 Employee #9 (Assistant Director of Nursing) was then called into the Resident #4's room. He also acknowledged that the mattress was not in the correct functional setting for Resident #4 and stated, "I will get the key to unlock the pump and set it to his (Resident #4) weight range."	F 917		