STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2021

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WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(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 000	INITIAL COMMENTS An unannounced Long-Term Care Survey was conducted at Washington Center for Aging Services from June 13, 2021, to June 22, 2021. Survey activities consisted of a review of 56 sampled residents. The following deficiencies are based on observation, record review, resident, and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 175. 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	F 000	**Stoddard Baptist Global Care makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Law.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE LNHA | (X6) DATE 8/9/2021

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	F 000		

Dl - deciliter
DMH - Department of Mental Health
EHR - Electronic Health Record
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
PASRR - 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
QIS - Quality Indicator Survey
RN - Registered Nurse
ROM Range of Motion

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F 000	Continued From page 2 Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000	**F584 Safe/Clean/Comfortable/Homelike Environment**	**June 30, 2021**
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1) -(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584	**1. Privacy Curtain Holder (Bracket) in room #356 was tightened. Stained ceiling tile in room #353 was removed and replaced. Vent covers near resident rooms #257 and #261 were installed.** **2. Maintenance team conducted facility wide inspection of loose privacy curtain holder (bracket), stained ceiling tiles, ceiling vent covers and other devices to identify and repair or replace devices. No other privacy curtain holders (brackets), stained ceiling tiles or vent covers were noted.** **3. Facility Maintenance manager provided education to maintenance staff on 6/16/2021 on the importance of frequent rounding to identify and timely replacement or repair of loose privacy curtain holder (bracket), stained ceiling tiles, ceiling vent covers, and other devices as needed.** **4. The Maintenance team will conduct weekly inspection on loose privacy curtain holder (bracket), stained ceiling tiles, ceiling vent covers and other devices. Any device identified will be repaired or replaced.** **5. Weekly inspection of privacy curtain holders, ceiling tiles and vent covers will be monitored. A report of the inspection will be forward to the QAPI committee and reported on quarterly.**	

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F 584	Continued From page 3 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable environment as evidenced by a loose privacy curtain bracket in one (1) of 46 resident's rooms, stained ceiling tiles in one (1) of 46 resident's rooms, and two (2) of five (5) ceiling vents that lacked a cover in the hallway of unit 2 Orange. The findings include: During an environmental walkthrough of the facility on 06/15/2021, at approximately 10:00 AM: 1. The privacy curtain holder (bracket) in resident room #356 was noted to be loose, one (1) of 46 resident's rooms. 2. Ceiling tiles were stained in resident room #353, one (1) of 46 resident's rooms. 3. Two (2) of five (5) ceiling vent covers were missing in the hallway near resident rooms #257 and #261 on unit 2 Orange. During a face-to-face interview on 06/16/2021, at	F 584		

. Residents # 148 and # 161

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F 584	Continued From page 4 approximately 10:00 AM, Employee #5 acknowledged the findings and stated they had already been corrected.	F 584		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to	F 622	**F622 Transfer and Discharge Requirements** **1. A review of residents #148 and #161 was done. Unable to retrospectively correct deficiency.** **2. A review of other residents transferred via 911 was conducted. Unable to retrospectively correct for any resident who had already been sent the hospital.** **3. Hospital transfer package checklist was updated to include comprehensive care plan, goals, and approaches, as a part of document to be sent to the receiving facility. All Charge Nurses, nurse managers, and supervisors were in serviced by July 31st.** **4. Monitoring tool was initiated to track all current Residents that are being transferred to Hospital to ensure that the facility is incompliance. Findings will be reported at quarterly QA meetings.**	**July 31, 2021**

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F 622	Continued From page 5 § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner	F 622		

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F 622	Continued From page 6 responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to ensure all required documents were conveyed to the receiving health care provider for two (2) of 56 sampled residents that were transferred from the facility to the hospital. Residents' #148 and #161. The findings include: Review of, "Stoddard Baptist Global Care -Documents to be included in transfer packet" list the following items: "History and Physical signed, Current Medications Lists (POS [physical order sheet]); face sheet, Last physician notes; labs/microbiology/cultures (3 months); Facility transfer form; Guardianship/legal documents; Transfer order; DC (District of Columbia)-DNR (Do Not Resuscitate) comfort care; Problem List; and Advance Directives". The facility has a protocol for staff to complete a checklist before transferring residents. However, the form does not list "Comprehensive Care Plan Goals" as a document to be sent to the receiving facilities.	F 622		

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F 622	Continued From page 7 1. Resident #148 was admitted to the facility on 7/22/2020, with diagnoses that included Unspecified Dementia Without Behavioral Disturbance, Glaucoma, Ascarasis Pneumonia, Type 2 Diabetes Mellitus without complications, Hypertension, and Epilepsy. Review of the medical record revealed: Nurse progress note dated 3/16/21, "...about 2:15 PM resident was observed not responding to name call and simple commands. He was leaning towards his right hand; right hand was shaking but breathing and have palpable pulse...NP (Nurse Practitioner) order given to transfer resident via 911 to the nearest ER (emergency room) for further evaluation of unresponsiveness... Physician's order dated 3/16/21, showed, "Transfer resident via 911 for further evaluation of unresponsive." A review of the documents [transfer packet] sent to the emergency room with Resident #148 on 03/16/21 was conducted. There was no evidence that the resident's comprehensive care plan goals were included in the documents sent to the hospital (receiving provider). During a face-to-face interview with Employee #20 (Unit Manager) on 06/22/2021 at 10:50 AM, she acknowledged that comprehensive care plans goals were not sent to the hospital with the resident.	F 622		

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F 622	Continued From page 8 2. Resident #161 was admitted to the facility on 12/02/2020 with multiple diagnoses, including Fracture of Neck of Femur, Hypertension, Diabetes, Urinary Tract Infection, and Esophagitis with Bleeding. A review of the resident's medical record revealed the following: A) 04/14/21 at 9:34 PM [Nursing Progress Note] documented, " ... Resident noted with nausea and vomiting around 5:00 PM, seen by NP (nurse practitioner), received new order ...Around 8:15 PM, resident was noted again with ... projectile ground coffee-colored emesis ...received order to send Resident out to the hospital ...911 arrived at 8:40 PM and took Resident to [hospital's name] ..." 04/14/21 [Physician's Order]," Transfer resident via 911 due to projectile ground coffee emesis." B) 04/23/21 at 7:00 PM [Physician's Order], "Send to ER (emergency room) non-urgent for possible R (right) distal femur fracture ..." 04/23/21 at 10:56 PM [Nursing Note] documented, " ...around 7 PM this writer received a call [Xray company's name] about x-ray results ... show there is possible non displaced fracture of the distal femur, NP (nurse practitioner) made aware and orders given to ...send resident to ER (emergency room) non-urgent for possible right distal fracture ...resident left around 8:45 PM to [hospital's name] ..." 04/24/21 at 9:39 AM [Nursing Note] documented, "Resident return from follow up of possible right	F 622		

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F 622	Continued From page 9 distal femur [fracture] ... [hospital's name] ...CT (computerized tomography) scan today did not show sign of fracture or any new changes from prior hip fracture ..." A review of the documents [transfer packets] sent to the emergency room with Resident #161 on 04/14/2021 and 04/24/2021 was conducted. There was no evidence that the resident's comprehensive care plan goals were included in the documents sent to the hospital (receiving provider). During a face-to-face interview on 06/22/2021, at approximately 2:00 PM, Employee #4 (Unit Manager) stated, "We do not send the resident's care plans [goals] with them when they are transferred to the hospital."	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623	SEE NEXT PAGE	

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F 623	Continued From page 10 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623	**F623 Requirements Before Transfer/Discharge** **1) A review of resident's # 129 and #161 was conducted. Both residents are currently in the facility and no additional transfer to the hospital has occurred. Unable to retrospectively correct their deficiencies.** **2) A review of all residents transferred to hospital in the last quarter was conducted and no other resident was impacted by the deficient practice** **3) Resident representatives will be contacted by telephone, followed by a letter of notice of transfer with the rights of appeal and including a notice of receipt will be mailed to the family member. Once the notice of receipt has been received from the resident representative it will be attached to the original copy and filed for our records.** **4) Monthly audits will be conducted by the Admission staff for review of notice of transfer and discharge records with the right of appeal. Results of monthly audit will be reported in the quarterly QA meeting.**	**JULY 31, 2021**

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F 623	Continued From page 11 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 623		

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F 623	Continued From page 12 facility staff failed to provide residents and residents representatives with Notice of Discharge, Transfer or Relocation and the written Notices of a Statement of Appeal for two (2) of 56 sampled residents that were transferred to the hospital. Resident's #129 and #161. The findings include: 1. Resident #129 was admitted to the facility on 09/26/2017 with multiple diagnoses, including Wandering, Hypertension, Type 2 Diabetes, and Chronic Kidney Failure. A review of the resident's medical record revealed: 04/27/21 at 11:51 PM [Nursing Note] documented, " ...This writer calls to the hallway near room 110A by nursing assistants and observed resident lying on her right side on the floor at about 5:00 PM ...resident noted with small swelling/small abrasion to her right temple area of the head with little bleeding noted at the site ...NP(nurse practitioner) order resident to be transfer to the nearest ER (emergency room) for further evaluation ...transferred resident to [hospital name] at 9:15 PM." 04/27/21 at 8:00 PM [Physician's Order], "Send to ER (emergency room) 911 due to fall with head involvement." A review of Resident #129's written Notice of Discharge, Transfer or Relocation documents sent to their family representatives lacked documented evidence of a Notice of a Statement of Appeal.	F 623		

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F 623	Continued From page 13 2. Resident #161 was admitted to the facility on 12/02/2020, with multiple diagnoses, including Fracture of Neck of Femur, Hypertension, Diabetes, Urinary Tract Infection and Esophagitis with Bleeding. A review of the resident's medical record revealed the following: 04/14/21 at 9:34 PM [Nursing Progress Note] documented, " ...Resident noted with nausea and vomiting around 5:00 PM, seen by NP (nurse practitioner), received new order ...Around 8:15 PM resident was noted again with ... projectile ground coffee colored emesis ...received order to send resident out to the hospital ...911 arrived at 8:40 PM and took resident to [hospital's name] ..." 04/14/21 [Physician's Order], "Transfer resident via 911 due to projectile ground coffee emesis." 04/23/21 at 7:00 PM [Physician's Order], "Send to ER (emergency room)- nonurgent for possible R (right distal) distal femur fracture ..." 04/23/21 at 10:56 PM [Nursing Note] documented, "...around 7 PM this writer received a call [Xray company's name] about xray results ... show there is possible non displaced fracture of the distal femur, NP nurse practitioner made aware and orders given to ...send resident to ER (emergency room) nonurgent for possible right distal fracture ...resident left around 8:45 PM to [hospital's name] ..." A review of Resident #161's written Notice of Discharge, Transfer or Relocation documents sent to their family representatives lacked documented evidence of a Notice of a Statement	F 623		

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F 623	Continued From page 14 of Appeal. Review of the resident clinical records showed no documented evidence that the bed hold notice and the transfer or relocation form was provided to the resident or their responsible party as soon as practicable. During a face-to-face interview conducted on 06/22/2021, at approximately 3:30 PM, Employee #18 (Admission Director) stated that moving forward, she would include a Statement of Appeal with the (written) discharge documents sent to the resident's representatives. For residents who are their own responsible party, it will be inclued in the resident's records when they are transferred or discharged.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		

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F 625	Continued From page 15 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide written information to the resident or resident representative that explained the duration of their bed-hold for one (1) of 56 sampled residents that were transferred to the hospital. Resident #148. The findings include: Resident #148 was admitted to the facility on 07/22/2020, with diagnoses Unspecified Dementia Without Behavioral Disturbance, Glaucoma, Ascarasis Pneumonia, Type 2 Diabetes Mellitus Without Complications, Hypertension, and Epilepsy. Review of the medical record revealed: Nurse progress note dated 3/16/21, "...about 2:15 pm resident was observed not responding to name call and simple commands. He was leaning towards his right hand; right hand was shaking but breathing and have palpable pulse...NP (Nurse Practitioner) order given to transfer resident via 911 to the nearest ER (emergency room) for further evaluation of	F 625	**Past noncompliance: no plan of correction required.**	

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F 625	Continued From page 16 unresponsiveness..." Physician's order dated 3/16/21, "Transfer resident via 911 for further evaluation of unresponsive." Review of the clinical record lacked evidence that the resident or the resident's representative was notified of the number of remaining bed hold days within 24 hours of hospital transfer. During a face-to-face interview conducted on 06/22/2021, at approximately 3:30 PM, Employee #18 (Admission Director) provided the writer with the bed hold and stated it was mailed to the to the resident's representative.	F 625		
F 641 SS=E	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 observation, record review and staff interview for five (5) of 56 sampled residents, facility staff failed to accurately code the Minimum Data Set for one (1) resident who had episodes of anxiety; one (1) resident having impairment on one side; one (1) resident for dialysis; one (1) resident for shortness of breath, and for one (1) resident for discharge assessment. Residents' #60, #100, #134, #179 and #181. The findings include: 1. Resident #60 was admitted to the facility on	F 641	SEE NEXT PAGE	

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F 641	Continued From page 17 06/12/2018, with diagnoses that included: Peripheral Vascular Disease, Traumatic Brain Injury, Chronic Pain, Contracture, Gastrostomy Status and Mild Cognitive Impairment. Review of the Quarterly Minimum Data Set (MDS) dated 04/09/2021, revealed: Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired. Section E (Behavior) "Delusions (misconceptions or beliefs that are firmly held, contrary to reality)" is documented. Review of the physician's orders revealed the following: "7/21/2020 instructed staff to document, "Target behavioral symptoms (Refusing medications and wound treatment) every shift". "11/17/2020 Haloperidol (antipsychotic) 0.5mg (milligram) Administer 0.25mg via PEG [percutaneous endoscopic gastrostomy] tube daily for agitation Start Date once a day" Review of the June 2021 Medication Administration Record (MAR) revealed that facility staff documented that Resident #60 refused the Haloperidol on June 15th and 16th, 2021, during the day shift. However, in the "Target Behavior" section of the previously mentioned MAR, the facility staff documented, "00" for the number of episodes Resident #60 refused medications that occurred on June 15th and 16th, 2021, during the day shift. During a face-to-face interview conducted on	F 641	**F641 Accuracy of Assessment (#1)** 1. **Resident # 60 was reassessed. Facility cannot retrospectively correct inappropriate documentation.** 2. **Behavior monitoring on all Resident on Antipsychotic medications and documentations was reviewed. No other resident was affected by this practice.** 3. **Unit managers were reeducated and will review behavioral orders and nursing documentation weekly.** 4. **Unit managers will audit documentation on the MAR as it pertains to antipsychotic medications. The report will be submitted to the DON/ADON and reported to the QAPI report quarterly.**	**JULY 31, 2021**

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F 641	Continued From page 18 06/16/2021, at 12:28 PM, Employee #7 (Registered Nurse) acknowledged the finding that he incorrectly documented the assessment of the resident and stated, "I documented "00" to indicate that the resident didn't have any episodes of anxiety instead of him refusing the medication." 2. Resident # 100 was admitted to the facility on 7/25/2016, with diagnoses that included Hemiplegia, Unspecified Affecting Left Nondominant Side and Aphasia. According to the Minimum Data Set completed 5/5/2021 Under Section G (Functional Status) Resident # 100 required extensive assistance with the assistance of one person for bed mobility, dressing, and personal hygiene. Under Section G0400 (Functional Limitation in Range of Motion) the resident was not coded as having impairment on one side- upper extremity (shoulder, elbow, wrist hand). Section I (Active Diagnoses) was coded as the resident having Hemiplegia, unspecified Affecting Left Nondominant side. Review of the Resident #100's care plan for "Left Hand Palm Guard" last updated 5/4/2021 showed the following approach "Left hand palm guard-4 hours on and 4 hours off, off at night" The physician's orders last signed and dated 6/3/2021 directed, "splint clarification order: palm guard to be applied on left hand by gently opening fingers and placing palm guard in hand, secure with strap ..." Observations: On 6/15/2021 at 1:00 PM and 6/17/2021 at 12:00	F 641	**F641 Accuracy of Assessment (#2)** 1. **The assessment of resident #100 with ARD 5/5/21 was modified to correctly code the functional limitation in range of motion.** 2. **Audit was conducted on the last Quarterly MDS and Annual MDS assessments in the last 6 months of all residents with splint and identified contracture. All identified missed functional limitation in ROM coding was modified.** 3. **In-service was held with all the MDS coordinators, and restorative nursing on proper identification and accurate coding of the functional limitation in range of motion.** 4. **The MDS manager will audit the MDS assessments of all residents with splints and identified contracture for correct coding of functional limitation in range of motion. The findings will be reported to QAPI committee quarterly.**	**JULY 31, 2021**

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F 641	Continued From page 19 PM Resident #100 was observed, and the hand splint/palm guard was not applied to his left hand. During a face-to-face interview conducted on 06/22/2021 at approximately 12:00 PM with Employee #9 (MDS Manager) he observed the resident and acknowledged that the MDS should have been coded for the resident having impairment on one side- upper extremity. 3. Facility staff failed to code a Quarterly Minimum Data Set for Resident #134's use of Dialysis. Resident #134 was admitted to the facility on 02/22/2019, with diagnoses, which included End-stage renal Disease on Hemodialysis, Hypertension, Diabetes Mellitus 2, , Gastroesophageal Reflux Disease, Anemia, Cerebral Infraction, Seizure and Dementia. A review of the Quarterly Minimum Data Set dated 05/08/2021 showed under Section O (Special Treatments, Procedures and Programs) O100 #2 "while a resident" facility staff failed to code in section "Other J. Dialysis" The box next to "Dialysis" was not checked indicating, it was not coded. During a face-to-face interview conducted on 06/22/2021, at 1:43 PM, Employee #17, reviewed the aforementioned MDS and acknowledged the findings. 4. Resident #179 was admitted to the facility on 04/15/2021, with diagnoses that included: Fatigue, Shortness of Breath (SOB), Acute	F 641	**F641 Accuracy of Assessment (#3)** 1. **The assessment of resident #134 with ARD 5/8/21 was modified to correctly code dialysis in section O0100(2)(K) of the resident's MDS assessment.** 2. **MDS Team audited accurate coding of Dialysis on MDS assessment within the past 6 months to identify missed coding of section O0100 (2)(K). No missed coding found.** 3. **In-service was conducted for all MDS coordinators on proper coding of dialysis in section O0100(2)(K) of MDS assessment:** 4. **The MDS manager will audit assessments of all dialysis resident at least once every month for MDS dialysis coding compliance. The findings will be reported to the QAPI committee quarterly.**	**JULY 31, 2021**

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F 641	Continued From page 20 Respiratory Failure with Hypercapnia, Chronic Lung Disease and Hypertension. Review of the Admission MDS dated 04/22/2021 revealed: Section I (Active Diagnoses) - Acute Respiratory Failure with Hypercapnia, Hypertension, Obstructive Sleep Apnea. Section J (Health Conditions) subsection "J1100 Shortness of Breath (dyspnea)", facility staff documented, "none of the above". Review of the physician's orders revealed: "04/16/2021 O2 (oxygen) @ (at) 2l (liters)/min via NC (nasal canula) for sob (shortness of breath) Every Shift Night, Day, Evening Start Date" "04/16/2021 Montelukast (anti-inflammatory) tablet; 10 mg; amt (amount): 1 tab (tablet); oral Special Instructions: Montelukast 10 mg 1tab oral at night for COPD (chronic obstructive pulmonary disease) at bedtime" Review of the Care Plan revealed: "04/15/2021 Problem: Resident has shortness of breath R/T (related to) Respiratory Failure, Resident receives Oxygen at 2L/min via nasal cannula..." "04/15/2021 Problem: Resident has needs related to respiratory disease: Chronic Lung Disease with Hypercapnia/Respiratory Failure/COPD/SOB..." The admissions MDS lacked documented evidence that Resident #179 was coded as	F 641	**F641 Accuracy of Assessment (#4)** 1. **The assessment of resident #179 with ARD 4/22/21 with the coding error was modified to accurately code shortness of breath in section J100.** 2. **Audit was conducted on MDS assessments of residents in the last 6 months with continuous oxygen. All identified missed coding of shortness of breath were modified.** 3. **In-service was conducted for MDS coordinators on proper coding, and documentation of shortness of in section J100.** 4. **MDS manager will audit MDS assessments of all residents on continuous oxygen every 3 months for accurate coding of section J100. The findings will be reported in QAPI quarterly.**	**JULY 31, 2021**

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	(5) Findings will be reported in QA			
F 641	Continued From page 21 having Shortness of Breath. During a face-to-face interview conducted on 06/17/2021, at 1:34 PM, Employee #8 (MDS Coordinator) stated, "It was not documented properly in the MDS." 5. Resident #181 was admitted to the facility on 04/03/2021, with diagnoses that included: Cancer, Anemia, Diabetes Mellitus and Non-Alzheimer's Dementia. Review of the progress notes revealed the following: 04/27/2021 at 11:38 AM [Nursing Discharge Note]: "Resident was discharged home today (4-27-21) and his RP [resident's representative] (wife) and his son picked up the resident ..." Review of the Discharge MDS dated 04/27/2021, in section A2100 (Discharge Status) revealed that facility staff coded Resident #181's discharge as "03" indicating the resident was discharged to an "Acute hospital". During a face-to-face interview conducted on 06/17/2021, at 4:22 PM, Employee #8 (MDS Coordinator) acknowledged the findings.	F 641	**F641 Accuracy of Assessment (#5)** **1. The assessment of resident #181 with ARD 4/27/21 was modified to accurately code discharge status in section 'A1200'.** **2. Audit was conducted on all discharged residents in the last 6 months. No inaccurate coding identified.** **3. In-service conducted for MDS coordinators on proper coding of discharge status in section 'A1200'.** **4. MDS manager will audit all discharge assessments for accurate coding of discharge status in section 'A1200'. The findings will be reported to QAPI committee in quarterly report.**	**JULY 31, 2021**
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	F 657	**SEE NEXT PAGE**	

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F 657	Continued From page 22 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 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 56 sampled residents, facility staff failed to update a resident's care plan to address one (1) resident with iron deficiency-anemia to include person-centered measurable objectives and time frames and for one (1) resident with a perm-a-cath access site for dialysis treatment. Residents' #99 and #134. The findings include: 1.Facility staff failed to update Resident #99's iron deficiency anemia care plan to include person-centered measurable objectives and time frames.	F 657	**F657 Care Planning Timing and Revision** **1. a. Resident #99 was reassessed, and the care plan was reviewed. Anemia care plan was updated to include measurable objectives and time frames to meet the resident's goals such as monitoring for bleeding in urine and bleeding gums.** **b. Resident #134 was reassessed. Previous Care plan was updated with goals and approaches to address resident's use of perm-a-cath for dialysis.** **2. All residents with the diagnosis of anemia's care plan were identified; plan of care reviewed and none of them were affected by this deficient practice. All other Residents using perm-a-cath for dialysis were identified plan of care reviewed and were incompliance.** **3. All unit managers and supervisors were in-serviced on how to update plan of care for new diagnoses and how to use person centered goals with measurable objectives for the resident's plan of care to include new goals and approaches as indicated for the resident.** **4. An audit was developed to monitor the care plans to ensure that the care plans are updated to include person centered measurable goals and approaches. The nursing management team will conduct the audits submit to DON or ADON for further review and submitted to QAPI committee quarterly.**	**JULY 31, 2021**

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Resident #99 was admitted to the facility on 05/06/2020, with diagnoses that included: Anemia, Hypertension, Renal Insufficiency, Viral Hepatitis C, Diabetes Mellitus, Depression and Chronic Obstructive Pulmonary Disease (COPD).

Review of the physician's orders revealed the following:

"06/02/21 Ferrous sulfate tablet, delayed release 325 mg (milligram) ... administer 1 tablet by mouth daily for anemia..."

"6/7/21 CBC [complete blood count] on Mondays..."

"06/09/2021 Head to toe skin observation for any abnormalities (bruises ... discoloration) twice a week on shower days Monday and Friday... Record abnormalities in the nurses note. "

Review of the progress notes revealed the following:

04/21/2021 at 6:50 PM [physician's note] Resident is a 67 years old male re-admitted to the facility from VAMC [Veterans Administration Medical Center] to unit 2 orange at 6:40 PM after recent hospitalization on 4/12/21 due to low H &H [hemoglobin and hematocrit] ... PMHD [past medical history diagnosis] Chronic anemia ..."

04/24/2021 at 11:01 AM [Attending Physician Note] ... Problems: 1) Chronic Anemia ...He has had numerous admissions to the hospital for GI [gastrointestinal bleed] and anemia, required 7 units PRBCs [packed red blood cells] in March

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F 657	Continued From page 24 [2021] and his most recent admission he received 6 units of PRBCs ...Assessment ... The poor production of clotting factors is the most likely reason he continues to have bleeding, as well as the likelihood that he has esophageal varices ..." 05/11/2021 at 4:32 PM [Nursing Note] This resident went out to a VA [Veterans Administration] clinic and returned at about 12:30 pm and at about 1:00 Pm this writer got a call from [VAMC doctor] stating that the HBG [hemoglobin] result that was done during the morning visit is 6 and resident needed to return to the Hospital for blood transfusion. Resident left for the transfusion at about 1:35 pm ..." 06/01/2021 at 8:20 PM [Nursing Note] Resident is 67 years old male re-admitted to the facility from VAMC at 4: 00 pm to unit 2 orange room 260-P after hospitalization 5/11/21 for low H&H of 6. Resident received 7 u [units] PRBC ..." Review of the care plan on 06/16/2021, revealed: " ... Problem: Has discomfort related to iron deficiency anemia. Category Anemia Start Date 05/08/2020 Last Reviewed/Revised 03/10/2021 at 10:25 AM The care plan lacked documented evidence that Resident #99's care plan included measurable objectives and time frames to meet the residents goals such as monitoring for bleeding (petechiae, blood in the urine, bleeding of the gums). During a face-to-face interview conducted on 06/16/2021, at 2:53 PM with Employee #9 (Unit Manager), she stated, "The nurse managers will update the care plan on admission and for any	F 657		

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F 657	Continued From page 25 new diagnoses. He [Resident #99]does not have the goals and approaches in place to monitor for bleeding, but it is something that we do." 2.Resident #134 was admitted to the facility on 02/22/2019, with diagnoses that included End-Stage Renal Disease on Hemodialysis, Hypertension, Diabetes Mellitus 2,Gastroesophageal Reflux Disease, Anemia, Cerebral Infraction, Seizure and Dementia. A review of the Quarterly MDS (Minimum Data Set) dated 05/08/2021 revealed in Section C, (Cognitive Patterns) the resident had a Brief Interview for Mental Status (BIMS) score of "01", indicating severe cognitive impairment. Section I (Active Diagnosis) End-Stage Renal Disease was documented. Subsection I8000 (Addtional active diagnoses)" it documented, "Dependence on renal dialysis". A physician's telephone order dated 5/19/2021 at 9:25 AM revealed, "Transfer resident to [hospital name] for Access Evaluation (AVF [arteriovenous fistula] Ulcer)" A review of the progress notes showed the following: 5/19/2021 at 12:41 PM [Nursing Note] "Resident left to dialysis at 9:15 AM and back to unit at 9:30 AM with referral to ER (emergency room) for Access site ulcer. Resident transferred to [hospital name] ER at10:00 AM ..." 5/19/2021 at 6:50 PM [Nursing Note] "[Hospital Name] called to check on resident status resident	F 657		

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F 657	Continued From page 26 is going to be admitted" 5/21//2021 at 11:52 PM [Nurse Practitioner Note] "Seen and examined for re-admission, she had a brief hospitalization 2/2 [secondary to] infected AVF now has left upper chest perm-a-cath, left forearm old dialysis access with closed incision sutures intact" A review of Resident #134's dialysis care plan with a start date of 01/27/2021 lacked documented evidence that facility updated the previously mentioned care plan with goals and approaches to address the resident's use of a perm-a-cath for dialysis starting on 05/21/2021. During a face-to-face interview conducted on 06/17/2021, at 10:43 AM with Employee #14 (Registered Nurse), he acknowledged the findings.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for two (2) of 56 sampled residents, facility staff failed to ensure that residents received treatment and care in accordance with	F 684	SEE NEXT PAGE	

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F 684	Continued From page 27 professional standards of practice as evidence by: failure to follow the hospital discharge instructions to continue the administration of an antibiotic for two days to treat one (1) resident with a diagnosis of a urinary tract infection, and to apply the palm guard to one (1) resident's left hand in accordance with the physician's order. Residents' #29 and #100. The findings include: 1. Facility staff failed to ensure that hospital discharge instructions to continue antibiotic for two days (01/13/21 and 01/14/21) was acted upon in a timely manner. Resident #29 was admitted to the facility on 01/12/2021, with diagnoses, which included Hypertension, Diabetes Mellitus 2, Hyperlipidemia, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident, Seizure and Dementia. Review of the Hospital Discharge Summary dated 1/12/2021 at 13:23 [1:23 PM] that was intialed by faclity staff (indicating that the discharge summary was reviewed) showed the following: "Patient was found to have high leukocyte esterase, WBC's (white blood cells), and RBC's (red blood cells) on U/a (urinalysis) and was treated with one dose of Zosyn (antibiotic) in the ED (emergency department) UTI (urinary tract infection) ... Continue Ceftriaxone (antibiotic) 1g (gram) IV (intravenous) q (every) x 7days (1/8 - 1/14). Today is day 5 [indicating that the resdient had recieved 5 of the 7 doses of the IV antibiotics that were ordered] ..."	F 684	**F684 Quality of Care** 1. **a. A review of resident #29 was conducted. Upon assessing the resident there was no signs/symptoms of infection, unable to retrospectively correct deficiency.** **b. A review of resident #100 was done. Another Palm guard was obtained from the Physical Therapy department for the residents.** 2. **All residents with physician's orders for antibiotics was reviewed. The Medication Administration Record was reviewed. No other resident was affected by this practice. A review of residents with orders for Palm guard was also conducted and no other resident was found to be affected by this practice.** 3. **The nursing staff were re-educated on the use of Antibiotics, Palm guard and following physician's orders.** 4. **A monitoring tool was initiated to track all residents with antibiotic use by Infection Preventionist. A list of residents that required splint/palm guards was compiled and distributed to restorative nursing team for monitoring. The findings will be presented to QAPI Committee quarterly.**	**July 31, 2021**

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F 684	Continued From page 28 Review of Medication Administration Record (MAR) from 01/12/2021 to 01/31/2021 lacked documented evidence that facility's staff administered the remaining two (2) doses of Ceftriaxone 1 gm IV. Review of the February MAR dated from 02/01/2021 to 02/13/2021 revealed that the facility's staff administered the Ceftriaxone 1 gm Intramusclar on 02/12/21 and 02/13/21. (It should be noted the previously medication was administered 30 days after the discharge instructions). There was no documented evidence that facility staff ensured the hospital discharge instructions to continue Ceftriaxone (antibiotic) for (two) 2 days for Resident #29 was acted upon in a timely manner. The resident was discharged from hospital on 01/12/2021, however, Ceftriaxone 1gm IM every 12hrs x 2 doses was not administered until 2/12/2021. During a face-to-face interview on 6/17/2021 at approximately 10:43 AM, Employee #14 (Registered Nurse) acknowledged the findings. 2. Facility staff failed to apply the palm guard to one (1) resident's left hand in accordance with the physician's order. Resident # 100 was admitted to the facility on 7/25/2016 with diagnoses that included Hemiplegia, unspecified Affecting left nondominant side and Aphasia. According to the Minimum Data Set completed	F 684		

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F 684	Continued From page 29 5/5/2021, Under Section G (Functional Status), Resident # 100 required extensive assistance with the assistance of one person for bed mobility, dressing, and personal hygiene. Under Section G0400 (Functional Limitation in Range of Motion), the resident was not coded as having impairment on one side- upper extremity (shoulder, elbow, wrist, hand). Section I (Active Diagnoses), was coded as the resident having Hemiplegia, unspecified Affecting Left Nondominant side. Review of the Resident #100's' care plan for "Left Hand Palm Guard" last updated 5/4/2021 showed the following approach, "Left hand palm guard-4 hours on and 4 hours off, off at night" The physician's orders last signed and dated 6/3/2021 directed, "splint clarification order: palm guard to be applied on left hand by gently opening fingers and placing palm guard in hand, secure with strap. On at 9:00 am, off at 1pm, on 5pm, off 9pm until am ..." Observations: On 06/15/2021 at 1:00 PM and 06/17/2021 at 12:00 PM Resident #100 was observed not wearing the hand splint/palm guard to his left hand as directed by the physician's order. During the face-to-face interview conducted on 6/17/2021 at 10:30 AM with Employee #9 (Unit Manager), she observed the resident not wearing a splint/palm guard on the resident's left hand. At the time, she looked around the resident's personal area and through the resident's belongings and did not find the splint/plam guard.	F 684		

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F 689	Continued From page 30		**Free of Accident Hazards/Supervision/Devices**	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to provide an environment free from accident hazards as evidenced by surge protectors that were observed in use, on the floor of two (2) of 46 resident's rooms and an extension cord that was observed in one (1) of 46 resident's rooms. The findings include: 1. Surge protectors were observed in use, on the floor of resident's room #310 and #320, two (2) of 46 resident's rooms. 2. An extension cord was observed in use, in one (1) of 46 resident's rooms resident room. (#377). During a face-to-face interview on 06/16/2021, at approximately 10:00 AM, Employee #5 (Engineer Manager) acknowledged the findings and stated they had already been corrected.	F 689	**1) Identified surge protector on the floor in room #310 and #320 were removed on 6/15/2021. The Extension Cord in resident room #377 was removed on 6/15/2021. No negative outcome was noted to Facility Residents.** **2) Maintenance team conducted facility wide inspection of surge protectors, extension cords and other safety devices to identify and repair or replace as needed. No other surge protectors or extension cords were noted.** **3) Facility Maintenance manager provided education to maintenance staff on 6/16/20121 on the importance of frequent rounding to identify and remove surge protector and extension cords on the floor and/or in the resident's room. The Maintenance team will conduct weekly Inspection on surge protector, extension cords and other safety devices. Any identified surge protector or extension cords on the floor will be removed.** **4) Weekly inspection of surge protectors and extension cords will be monitored. A report of the inspection will be forward to the QAPI committee and reported on quarterly.**	**June 30, 2021**
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756	**SEE NEXT PAGE**	

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F 756	Continued From page 31 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756	**F756 Drug Regimen Review** 1. **A review of residents #60, 162, and 177 was done. The Pharmacist updated the Medication Regimen Review (MRR) to ensure it was completed correctly.** 2. **A review of all residents' MRR was conducted. Corrections were made as indicated.** 3. **The Pharmacy was contacted and advised that MRR must be done timely and accurately. A follow-up memo was sent to the pharmacy.** 4. **The unit secretaries will monitor record, completely and dated appropriately monthly. It will be reported to the Medical Records Director. The findings will be presented in the QAPI Committee meeting quarterly.**	**JULY 31, 2021**

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F 756	Continued From page 32 Based on record review and staff interview, for three (3) of 56 sampled residents, facility staff failed to conduct a Medication Regimen Review (MRR) at least monthly. Residents' #60, #162 and #177. The findings include: Review of the facility's policy entitled, "Consultant Pharmacist Services" revealed, "... Reviewing the medication regimen of each resident at least monthly, complying with Federal, State, and Local mandated standards of care in addition to other applicable standards, and documenting the review and findings in consulting software ..." 1. Resident #60 was admitted to the facility on 06/12/2018, with diagnoses that included: Peripheral Vascular Disease, Traumatic Brain Injury, Chronic Pain, Contracture, Gastrostomy Status and Mild Cognitive Impairment. Review of Resident #60's record revealed that there was no MRR done for the month of May 2021. During a telephone interview conducted on 06/16/2021, at 1:06 PM, Employee #10 (Pharmacist) stated, "I am not sure if I have a MRR for this resident for May. I do a review monthly for all residents in the building but sometimes it goes over a month between reviews." 2. Resident #162 was admitted to the facility on 05/05/2020, with diagnoses, which included	F 756		

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F 756	Continued From page 33 Chronic Kidney Disease, Congestive Heart Failure, Hypertension, Hyperlipidemia, Seizures, Gastroesophageal Reflux Disease, Bipolar Disorder, and Major Depression. A review of the Medication Regimen Review progress notes dated from July 2020 to June 2021, lacked documented evidence that the pharmacist conducted a MRR for October 2020. During a face-to-face interview conducted with Employee #14 (Registered Nurse) on 06/16/2021, at approximately 1:00 PM, she reviewed the documents and acknowledged the findings. 3. Resident #177 was admitted to the facility on 07/15/2016, with diagnoses, which included Dementia, Hypertension, Diabetes Mellitus, Hypercholesterolemia, Peripheral Vascular Disease, and Chronic Obstructive Pulmonary Disease. A review of the Medication Regimen Review progress notes dated from May 2020 to June 2021, lacked documented evidence that the pharmacist conducted a MRR for September 2020 and March 2021. During a face-to-face interview conducted with Employee #14 (Registered Nurse) on 06/16/2021, at approximately 1:00 PM, she reviewed the documents and acknowledged the findings.	F 756		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when	F 773	SEE NEXT PAGE	

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F 773	Continued From page 34 ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 56 sampled residents, facility staff failed to promptly notify the ordering physician of laboratory results that fall outside of a clinical reference range in accordance with facility policies and procedures for notification. Residents' #7 and #99. The findings include: Review of the facility's policy entitled, "Documentation Requirements", item #12 "Laboratory, X-rays, and other tests", revealed, "Results of laboratory and x-ray studies are documented in the record. It is documented by a licensed nurse that the attending physician was notified of the abnormal results." Review of the facility's policy entitled, "Lab Results", revealed, " ... Once the physician has been notified, a notation must be made on the lab slip regarding date, time, signature of reporting person and a brief description of orders, if any; followed by documentation in the clinical record ..."	F 773	**F773 Labs Srvcs Physician/Notify of Results** **1. Resident #7's lab was re-evaluated two additional times, after which the medication was adjusted, and lab was done to ensure it met resident's needs. Resident #99 was re-evaluated, and physician was notified. The nursing staff documented this notification.** **2. A review abnormal lab for CBC and TSH was conducted. No other resident was found to be affected by this practice.** **3. The nursing management team was re-educated on the importance of monitoring lab results and notification of results timely. Additionally, they were re-educated on the importance of documenting that the physician or physician extenders were notified.** **Daily lab monitoring log was established to monitor all labs to ensure compliance. Labs will be reported daily via 24 Hr. report as well as documented in resident medical record** **4. The nurse managers will audit the medical records for lab results, notification of physician as indicated as well as documented the findings. This will be reported to the DON/ADON and QAPI Committee quarterly.**	**July 31, 2021**

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F 773	Continued From page 35 1. Resident #7 was admitted to the facility on 12/01/2018, with multiple diagnoses, including Hypothyroidism, Anxiety and Mild Cognitive Impairment. A review of the resident's medical record revealed the following: 02/06/21 [Physician's Order], " ...TSH (thyroid-stimulating hormone) [lab] ...hypothyroidism ...every three (3) months." 04/11/21 [Physician's Order], "Synthroid (treats hypothyroidism) 25mcg (micrograms) PO (by mouth) daily for thyroid hormone deficiency." A review of a document from the facility's consultant pharmacist entitled, "Note to Attending Physician/Prescriber" documented, "Patient had a high TSH [lab] of 19.683 on 3/4/21. Current dose of Synthroid is Synthroid 25 mcg (micrograms) daily. Recommend consider increasing the dose and re-checking lab in 8 weeks." The nurse practitioner initialed the previously mentioned document on 04/12/2021 (indicating he reviewed and agreed with the pharmacist's recommendations). 04/13/21 [TSH Lab Results], "TSH level "17.719 (H [high]) ... Range: 0.350-4.940 ..." A review of the lab results dated 04/13/2021 and nursing progress notes from 04/13/2021 to 06/16/2021 lacked documented evidence the nursing staff informed the physician or nurse practitioner of Resident #7's elevated TSH level on 04/13/2021.	F 773		

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F 773	Continued From page 36 During a face-to-face interview conducted on 06/16/2021 at approximately 12:30 PM, Employee #4 (Unit Manager) stated that she did not see any documentation in the resident's record that the charge nurse or the nursing staff informed the physician or nurse practitioner of Resident #7's 04/13/21 elevated TSH level. During a face-to-face interview conducted on 06/16/2021, at approximately 1:00 PM, Employee #23 (physician) stated, "I don't know how the labs were missed. It should not have happened." When asked if Resident #7's Synthroid will remain at 25 mcg daily, he stated that he would probably increase it to "50 mcg daily," but he needed to assess the resident. 2. Resident #99 was admitted to the facility on 05/06/2020, with diagnoses that included: Anemia, Hypertension, Renal Insufficiency, Viral Hepatitis C, Diabetes Mellitus, Depression and Chronic Obstructive Pulmonary Disease (COPD). Review of the physician's orders revealed the following: "6/7/21 CBC [complete blood count] on Mondays, " Review of the Resident #99's CBC results revealed the following: "06/07/21 ...Hemoglobin 7.7 (CL [critically low]) Reference Range 13.5- 17.5 g (grams)/dl (deciliter) ..." "06/10/21 ...Hemoglobin 7.4 (CL) Reference	F 773		

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F 773	Continued From page 37 Range 13.5- 17.5 g/dl ..." "06/15/21 ...Hemoglobin 7.4 (CL) Reference Range 13.5- 17.5 g/dl ..." Review of the Resident #99's medical record from 06/07/2021, to 06/15/2021, to include progress notes, lacked documented evidence that the ordering physician was notified of the aforementioned laboratory results and made aware of the abnormal laboratory results. During a face-to-face interview conducted on 06/16/2021, at 2:53 PM, Employee #9 (Unit Manager) stated that their policy and practice is to notify the nurse practitioner of any abnormal results and he will give instructions on the next steps. She also stated, "I know the nurses called the nurse practitioner, they must have forgot to document it."	F 773		
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-	F 842	SEE NEXT PAGE	

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F 842	Continued From page 38 (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- (i) Sufficient information to identify the resident;	F 842	**F842 Resident Records Identifiable Information** **1) A review of residents #7, 60, 162 and 177 was done. The Pharmacist updated the Medication Regiment Review (MRR) to ensure it was completed correctly. The Physician was contacted regarding the History and Physical (H&P). The H&P was completed. Resident #148 was reassessed. Unable to retrospectively correct documentation on AV fistula instead of Perm-A-Cath; however, moving forward dialysis access site will be documented correctly.** **2) A review of all resident's MRR and H&P were conducted. Corrections were made as indicated. A review of resident's dialysis access site was conducted; no other residents were affected.** **3) The Pharmacy was conducted and advised that MRR must be done timely and accurately. A written memo was sent to all medical providers to ensure all H&Ps are completed timely and accurately. The nursing staff were educated regarding documentation of the access site for dialysis.** **4) The unit secretaries will monitor records to ensure MRR and H&Ps are documented in the record, completely and dated appropriately monthly. The nursing management team will monitor documentation of dialysis access site. The findings will be presented in the QAPI Committee meeting quarterly.**	**JULY 31, 2021**

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F 842	Continued From page 39 (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, facility staff failed to: complete the residents Medication Regiment Review (MRR) assessment in accordance with accepted professional standards of practice for three (3) residents, to ensure one (1) residents History and Physical was dated on completion and failed to document the correct dialysis access location for one (1) resident. Residents' #7, #60, #148, #162, and #177. The findings include: Review of the facility policy entitled, "Consultant Pharmacist Services" revealed, " ...Reviewing the medication regimen of each resident at least monthly, complying with Federal, State, and Local mandated standards of care in addition to other applicable standards, and documenting the review and findings in consulting software ..." 1. Facility staff failed to complete MRR assessment in accordance with professional standards of practice. A. Resident #7 was admitted to the facility on 12/1/2018 with multiple diagnoses, including	F 842		

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F 842	Continued From page 40 Hypothyroidism, Dementia without Behaviors, Anxiety, and Restlessness. A review of the resident's Medication Regimen Reviews (MMR) dated 03/01/2021, 05/03/2021, and 06/02/2021, documented, "MRR completed." The reviews lacked documented evidence of the pharmacist's findings. During a face-to-face interview conducted on 06/15/2021 at approximately 11:00 AM, Employee #3 (Assistant Director of Nursing) stated that during the monthly MRRs, pharmacists are to write all their findings in the resident's medical record and not just write "MRR complete." 2. Resident #60 was admitted to the facility on 06/12/2018, with diagnoses that included: Peripheral Vascular Disease, Traumatic Brain Injury, Chronic Pain, Contracture, Gastrostomy Status and Mild Cognitive Impairment. Review of Resident #60's record revealed that from January 2021 to June 2021, the Pharmacist documented, "MRR completed", with no rationale being stated for why no action was taken. During a telephone interview conducted on 06/16/2021, at 1:06 PM, the Pharmacist stated, "Once I do the review- if there is nothing for the physician, I write 'MRR complete' in my software. The 'MRR complete' just documents that it's been done. For residents with recommendations, a summary is emailed to the DON (Director of Nursing), Unit Manager and Medical Director for review and follow-up." 3. Resident #162 was admitted to the facility on	F 842		

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F 842	Continued From page 41 05/05/2020, with diagnoses, which included Bipolar Disorder, Chronic Kidney Disease, Congestive Heart Failure, Hypertension, Major Depression, Hyperlipidemia, Seizures, Gastroesophageal Reflux Disease, Review of Resident #162's progress notes showed that from July 2020 to June 2021, the pharmacist documented, "MRR completed", with no rationale on information reviewed and what actions were taken. During a face-to-face interview on 06/16/2021, at approximately 11:00 AM, Employee #14 (Registered Nurse) acknowledged the finding. 4. Resident #177 was admitted to the facility on 07/15/2016, with diagnoses, which included Dementia, Hypertension, Diabetes Mellitus, Hypercholesterolemia, Peripheral Vascular Disease, and Chronic Obstructive Pulmonary Disease. A. Review of Resident #177's progress notes showed that from May 2020 to June 2021, the Pharmacist documented, "MRR complete", with no rationale on information reviewed and what actions were taken. A face-to-face interview was conducted with Employee #14 on 06/16/2021, at approximately 11:00 AM. After a review of the documentation and not able to reach the Pharmacist by telephone, Employee #14 acknowledged the findings. B. Facility staff failed to ensure Resident #177's history and physical (H&P) was dated on	F 842		

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F 842	Continued From page 42 completion. Resident #177 was admitted to the facility on 07/15/2016, with diagnoses, which included Dementia, Hypertension, Diabetes Mellitus, Hypercholesterolemia, Peripheral Vascular Disease, and Chronic Obstructive Pulmonary Disease. A review of Resident #177's medical record showed a completed, hand written H&P with the resident's name, the attending physician's name with no date of completion to indicate when the H&P was conducted. During a face-to-face interview conducted with Employee #14 on 06/17/2021, at approximately 11:00 AM, the Employee acknowledged the findings and later returned a copy of the H&P with a date of 5/27/2020. 5. Resident # 148 was admitted to the facility on 5/18/2021 with diagnoses with included: Type 2 Diabetes Mellitus Without Complications, Hypertensive Chronic Kidney Disease with Stage with Chronic Kidney Disease or End Stage Renal Disease (ESRD). A physician's order dated 06/09/2021 directed: "Hemodialysis with [name of dialysis center] on Mondays, Wednesdays and Fridays secondary to ESRD." "Monitor: Right chest perm-a-cath site for redness around catheter or soreness ...every shift; night, day, evening." Review of the Dialysis Center Report form dated 5/28/2021 showed, " Part 1: Completed by	F 842		

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F 842	Continued From page 43 Stoddard Baptist Global Care [WCAS] Pre-Dialysis: ...Access Location: RT (right) AV (arteriovenous) Fistula. Did you hear a bruit? Yes" Facility staff documented that Resident #148 had an AV fistula instead of a perm-a-cath. During a face-to-face interview with Employee #21 (Unit Manager) on 06/17/2021 at 4:15 PM she acknowledged that the resident has a perm-a-cath and the staff recorded the resident's dialysis access site incorrectly.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	SEE NEXT PAGE	

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F 880	Continued From page 44 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	**F880 Infection, Prevention, Control** **The F880 POC for the 2567 is also the same POC for the DPOC.** **1. The Trash in the trash can was immediately discarded in a trash can with a liner in it and a liner was placed in the trash car without the liner. The two empty soap dispensers were immediately filled. The employee #12 was re-educated regarding the use of the face shield.** **2. All observation rooms were checked, and all trash cans were noted to have red liners. All rooms on all units were checked to ensure soap dispensers were filled, no other dispenser was noted to be affected by this practice. A review of the unit was conducted, and no other staff member was noted to be without their face shield.** **3. A detailed Root Cause Analysis was done to ensure that corrective action would prevent reoccurrence of Infection Control practices. The nursing and housekeeping staff was in-serviced on liners for trash can as well as notification of housekeeping when soap dispensers are empty. All staff was re-in-serviced on the face shield requirements.** **4. An Infection Control audit is done monthly to address IC areas including lining of trash cans, soap dispensers and use of face shields and other PPE as maybe indicated. This information is reported to QAPI quarterly.**	**July 31, 2021**

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F 880	Continued From page 45 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, on three (3) of three (3) observations, facility staff failed to maintain infection control and prevention practices in accordance with standards of practice to minimize the potential spread of infections. The findings included: 1. Review of the facility's policy entitled, "Occupied Resident Isolation Room Cleaning- Contact, Strict Contact and Droplet Isolations" revealed, "Reline all trash liners." During a tour of room 260 on unit 2 Orange on 06/14/2021, at 2:30 PM, a red trash can was observed with no trash bag, with used discarded personal protective equipment inside. It should be noted that room 260 is on the COVID-19 observation unit where strict contact and droplet transmission-based precautions were in place. During a face-to-face interview conducted on 06/14/2021, at 2:35 PM, Employee #11 (Registered Nurse) stated, "I am not sure who put the items in the trash can. They shouldn't have put any trash inside without a trash bag. The unit manager was made aware and called housekeeping." 2. During a tour of unit 2 Orange on 06/17/2021, at 1:19 PM, it was noted that two (2) soap dispensers at two (2) separate hand washing stations were empty.	F 880		

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F 880	Continued From page 46 During a face-to- face interview conducted on 06/17/2021, at approximately 1:30 PM, Employee #9 (Unit Manager) stated, "I am calling housekeeping right now to address it." 3. During a tour of unit 3 Orange on 06/13/2021, at approximately 7:45 AM, Employee #12 (Certified Nurse Aide) was observed not wearing a face shield while performing resident care. During a face-to-face interview conducted at the time of the observation, Employee #12 stated, "I don't wear it [face shield] because I wear glasses and it bothers my eyes." When asked if she has brought this to the manager attention, she stated, "I did not report it to anyone." During a face-to-face interview conducted on 06/22/2021, at 1:05 PM, Employee #13 (Infection Control Preventionist) stated, "We train and educate all the staff on the importance of PPE (personal protective equipment). I will be calling that staff member and talking to her."	F 880		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility	F 919	SEE NEXT PAGE	

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F 919	Continued From page 47 staff failed to maintain the call bell system in good working condition as evidenced by call bells that failed to initiate an audible or visual alarm when tested in five (5) of 46 resident's rooms. The findings include: During an environmental walkthrough of the facility on 06/15/2021, at approximately 10:00 AM, call bell in five (5) of 46 resident's rooms did not emit an audible or visual alarm when tested. (rooms #314, #353, #361, #364, #379). This breakdown could prevent or delay care to residents in an emergency. During a face-to-face interview on 06/16/2021, at approximately 10:00 AM, Employee #5 (Engineer Manager) acknowledged the findings and stated they had already been corrected.	F 919	**F919 Resident Call System** 1. **Identified call bells that did not emit an audible or visual alarm in rooms #314, #353, #361, #364, #379 were corrected on 6/15/2021. No negative outcome was noted to Facility Residents.** 2. **Maintenance team conducted facility wide inspection of call bells on 6/15/2021 and other devices to identify and repair or replace as needed. No other call bell was identified.** 3. **Facility Maintenance manager provided education to maintenance staff on 6/16/2021 on the importance of frequent rounding to identify and timely replacement or repair call bells and other devices as needed. The Maintenance team will conduct weekly inspection on call bells and other devices. Any device identified will be repaired or replaced.** 4. **Weekly inspection of Call Bells will be monitored. A report of the inspection will be forward to the QAPI committee and reported on quarterly.**	**JUNE 30, 2021**