STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015382	A. Building B. Wing	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Health Care Facility	1720 Knowles Road Phenix City, AL 36869

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42883 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure one (Resident #40) of 34 sampled residents were assessed to self-administer their albuterol sulfate inhaler. Findings included: A review of the facility's policy titled, Self-Administration of Medications, revised 11/28/2016, revealed, 2. Facility, in conjunction with the Interdisciplinary Care Team, should assess and determine, with respect to each resident, whether Self-Administration of medication is safe and clinically appropriate, based on the resident's functionality and health condition. A review of Resident #40's Admission Record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/10/2023, indicated Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of Resident #40's comprehensive care plans revealed a care plan, revised on 01/17/2023, that indicated Resident #40 was at risk for shortness of breath related to a diagnosis of chronic obstructive pulmonary disease. This care plan directed staff to administer medications per physician's orders. Resident #40's comprehensive care plans contained no information related to self-administration of medications. A review of Resident #40's current physician's orders revealed an order dated 08/12/2022 for Proventil HFA (a medication used to treat or prevent wheezing and shortness of breath caused by breathing problems). This order did not indicate Resident #40 was assessed to self-administer the medication. On 05/30/2023 at 12:28 PM, Resident #40 was observed in bed. An albuterol sulfate 90 microgram (mcg) inhaler prescribed to Resident #40, dated 03/12/2023, was observed inside a roll of toilet paper on top of the resident's bedside table. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/31/2023 at 11:55 AM, Resident #40's albuterol sulfate inhaler was again observed inside a roll of toilet paper on top of the resident's bedside table. Resident #40 stated they had the inhaler for several days and that a night nurse (name unknown) gave it to him/her. Resident #40 said he/she used it mainly at night and that staff had never educated or told them they were not allowed to have medication at their bedside. Resident #40 said a nurse was in their room that morning to administer medications and did not say anything about the inhaler being there. During an interview on 05/31/2023 at 12:01 PM, Registered Nurse (RN) #6 stated she was in Resident #40's room earlier in the morning, around 8:00 AM, and gave the resident their morning medications. RN #6 was not aware Resident #40 had their albuterol inhaler. RN #6 said the albuterol inhaler was an as needed medication, and there was a different scheduled inhaler on the medication cart that the nurses provided on a routine basis. RN #6 confirmed Resident #40 had not been assessed to have medication at the bedside and said Resident #40 was not supposed to have the inhaler. RN #6 said this was not the first time Resident #40 had an inhaler when they were not supposed to. RN #6 stated it was not safe for Resident #40 to have the inhaler due to the resident's confusion. RN #6 stated Resident #40 could use it and not remember using it or not get a full dose. RN #6 also stated it was unsanitary, since the inhaler did not have a cap on it, and it was placed inside a toilet paper roll. During an interview on 06/02/2023 at 1:20 PM, the Assistant Director of Nursing (ADON) stated a nurse should not leave a resident's room until the resident had taken all their medications. The ADON said she expected all nurses to be mindful and aware while they administered medications or interacted with a resident. The ADON said nurses were expected to look in the immediate area of the resident to ensure there were no medications left at the resident's bedside during interactions. The ADON said she had never been informed Resident #40 had medications at the bedside and indicated if a nurse discovered medications at a resident's bedside, they should report that to their unit manager. The ADON said Resident #40 should not self-administer medications due to the resident's declining cognition. The ADON said it was acceptable for a nurse to hand the inhaler to the resident to use, but they should be there to supervise the resident use it and then take the inhaler from the resident before they left the room. During an interview on 06/02/2023 at 1:44 PM, the Director of Nursing (DON) stated there should not be any medications left at a resident's bedside. The DON said she expected staff to be aware and mindful and identify any items that could be a hazard, such as medications on a resident's bedside table. The DON said the concern for Resident #40 having the inhaler would be that either Resident #40 may not take the medication, or they may take the medication wrong due to the resident's cognition issues. During an interview on 06/02/2023 at 3:20 PM, the Administrator said he expected there to be no medications left at a resident's bedside. He also stated he expected all staff to pay attention to everything that went on in a resident's room. The Administrator said he did not know Resident #40 specifically, but indicated if a resident was not deemed safe to self-administer medications, the resident should not have the medication.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28196 Based on record review, interviews, and review of the Centers for Medicare & [and] Medicaid Services [CMS] Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment within 14 days of the completion date for one (Resident #32) of one resident reviewed for timely submission of MDS assessment. Findings included: A review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, revealed, Chapter 5: Submission and Correction of the MDS Assessments. Nursing homes are required to submit Omnibus Budget Reconciliation Act (OBRA) required Minimum Data Set (MDS) records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS). 5.1 Transmitting MDS Data All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. The RAI Manual further indicated, Transmitting Data: Submission files are transmitted to the QIES ASAP system using the CMS wide area network. The RAI Manual specified that discharge assessments must be submitted by Z0500B [completion date of the assessment] + [plus] 14 [days]. A review of Resident #32's Admission Record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. A review of Resident #32's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/07/2023, revealed the resident was discharged to the community on 01/07/2023. The completion date of the assessment was 01/12/2023. A review of Resident #32's MDS 3.0 Final Validation Report revealed their discharge assessment was not transmitted until 06/02/2023. During an interview on 06/02/2023 at 8:23 AM, MDS Coordinator #1 stated that MDS Coordinator #2 had completed the discharge assessment but failed to transmit it as required. She said it should have been transmitted within 14 days. During an interview on 06/02/2023 at 11:33 AM, the Director of Nursing (DON) stated that she expected MDS assessments to be transmitted within the timeframes specified by CMS guidelines. During an interview on 06/02/2023 at 3:10 PM, the Administrator stated that he expected MDS assessments to be transmitted in a timely manner.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42883 Based on interviews, record review, and facility policy review, the facility failed to complete a new Level I pre-admission screening and resident review (PASARR) after the resident was identified to have a newly evident mental illness diagnosis for one (Resident #2) of one resident reviewed for PASARR requirements. Findings included: A review of the facility's policy titled, PASRR [sic] Requirements, undated, revealed, In effort of the Health Information Management Coordinator to obtain a completed record, all patients must have a Pre-Admission Screening and Resident Review prior to or immediately upon admission as required by federal and/or a patient/resident specific review process as defined by local State guidelines. The PASRR [sic] is completed to determine provision of appropriate and needed serviced [sic] to individuals who have been diagnosed with MI/MR [mental illness/mental retardation]. A review of Resident #2's Admission Record revealed the resident was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. The Admission Record indicated the resident's diagnoses included panic disorder, paranoid schizophrenia, major depressive disorder, and bipolar disorder. Per the Admission Record, the diagnosis of bipolar disorder had an onset date of 10/19/2022. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/07/2023, indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment. Further review revealed active diagnoses of schizophrenia, bipolar disorder, major depressive disorder, and anxiety disorder. A review of Resident #2's comprehensive care plans revealed a care plan, initiated on 10/31/2022, that indicated the resident was receiving behavioral health services due to diagnoses of paranoid schizophrenia, bipolar disorder, major depressive disorder, and panic disorder. A review of a State of Alabama Department of Mental Health PASRR Level I Screening and Results, revealed a new Level I PASARR was not completed following Resident #2's diagnosis of bipolar disorder (which had an onset date of 10/19/2022) until 05/31/2023. During an interview on 06/01/2023 at 9:21 AM, the Corporate Nurse Consultant stated that after Resident #2's PASARR was requested by the surveyor, they identified there was an issue with the Level I PASARR screening not being completed. The Corporate Nurse Consultant indicated they had just completed Resident #2's new Level I screening on 05/31/2023. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/01/2023 at 3:42 PM, the Social Services Director (SSD) said the Admissions Coordinator was responsible for completing the initial Level I PASARR screening, and he was responsible for completing a new Level I screening if there was a change in the resident's condition or after a new diagnosis. The SSD said he just completed the new Level I PASARR screening for Resident #2 on 05/31/2023 due to the new diagnosis of bipolar disorder from October 2022. The SSD said he did not complete one at the time, in October 2022, because it slipped his mind, and he had no process in place to track changes when a resident had a new diagnosis. During an interview on 06/01/2023 at 3:30 PM, the Admissions Coordinator stated when residents were coming from Georgia (another state in close proximity to the facility), she completed the Level I PASARR screening, but if they were coming from Alabama, the hospital completed them. The Admissions Coordinator indicated she would review them for accuracy and complete a new one if there were any inaccuracies identified. The Admissions Coordinator said the SSD completed another Level I screening if there were any changes in the resident's diagnoses. During an interview on 06/02/2023 at 1:42 PM, the Director of Nursing (DON) stated a PASARR was completed by the Admissions Coordinator and signed by a registered nurse, and the SSD reviewed it for accuracy. The DON said if there was a change in a resident's condition, the SSD would review and submit another Level I screening for review to see if the resident qualified for a Level II referral. The DON said she was not aware that a new Level I PASARR screening was not completed in 2022 when Resident #2 had a new mental illness diagnosis and indicated she would have expected one to be done. During an interview on 06/02/2023 at 3:24 PM, the Administrator stated the facility received a referral for all new admissions, and after admission, if there were any changes, a new Level I screening was completed by the SSD. The Administrator said he expected this to be done.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 34575 Based on interviews, record review, and facility policy review, the facility failed to complete a discharge summary to include a recapitulation (a concise summary) of the resident's stay for one (Resident #123) of four sampled residents reviewed for discharge requirements. Findings included: Review of a facility policy titled, Discharge Summary Requirements, undated, revealed, Guidelines: To provide for a safe departure from the center and provide a summary of patient service provided during a length of stay and to include applicable continuum of care instructions to the patient and/or next care provider. The policy further indicated, The patient's attending physician should complete a Discharge Summary describing the patient's condition during the period of stay of which that physician was responsible for physician's care and services. 2. A center clinician should complete an Interdisciplinary Discharge Summary User Defined Assessment document that describes pertinent information related to the patient's current length of stay and to provide education to the patient and/or next care provider. Review of an Admission Record revealed the facility admitted Resident #123 on 11/01/2021 with diagnoses that included primary generalized osteoarthritis, muscle wasting and atrophy (weakening, shrinking, and loss of muscle caused by disease or lack of use) of the left and right thigh, chronic kidney disease, shortness of breath, dysphagia (difficulty swallowing), localized edema (swelling caused by fluid in the body's tissues), and chronic congestive heart failure. The Admission Record also indicated Resident #123 was discharged from the facility on 02/09/2022. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/27/2022, revealed Resident #123 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The resident required limited assistance with bed mobility, extensive assistance with transfers, locomotion, dressing, and eating, and was totally dependent on staff for toilet use and bathing. Review of Resident #123's Care Plan, initiated 11/23/2021, revealed the resident wanted assistance in planning to return home safely. This Care Plan directed staff to help the resident contact local agencies as needed and to develop transition strategies to make the discharge go smoothly. Review of Resident #123's Discharge Summary, dated 02/08/2022, revealed section A. Discharge Summary was not completed, with all related areas in this section blank. Section B. Recapitulation of Resident's Stay was incomplete and only had two entries completed in this section related to therapy services and a skin tear to the right lower leg. The Discharge Summary was not signed as completed and there was no acknowledgement that staff had provided and reviewed the discharge instructions with the patient/resident representative. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/02/2023 at 9:03 AM, the Corporate Nurse Consultant stated the discharge summary was a collaborative document opened in the electronic health record system. Each discipline was required to complete their respective sections, and once all sections were completed, that information would become the recapitulation of the resident's stay. The Corporate Nurse Consultant said at the time of a resident's discharge, the nurse should print off the discharge summary and review the information with the resident and the family. She further stated Resident #123's discharge summary was not completed and did not provide a recapitulation of their stay. During an interview on 06/02/2023 at 1:58 PM, the Administrator stated it was his expectation that staff would complete the discharge summary as required.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28196 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure one (Resident #25) of three sampled residents reviewed for activities of daily living (ADLs) were shaved and received hair care. Findings included: A review of a facility policy titled, ADL's [activities of daily living], effective August 2021, revealed, Policy: Ensure ADL's are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences. A review of Resident #25's Admission Record revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included noninfective gastroenteritis and colitis, diverticulosis of intestine, and gastrointestinal hemorrhage. A review of Resident #25's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/15/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The MDS further revealed Resident #25 required extensive assistance of one staff for personal hygiene and was totally dependent on one staff for bathing. A review of Resident #25's comprehensive care plans revealed a care plan addressing ADLs, initiated on 02/27/2023, that indicated the resident had an ADL deficit in relation to: Left BKA [below knee amputation]; right foot amputation; recent hospital stay per [for] diverticulosis and gastrointestinal hemorrhage; generalized weakness; incontinence; obesity; diabetes. This care plan directed staff to assist with bed mobility, bathing, dressing, grooming, and toileting. On 05/30/2023 at 9:20 AM, an observation was made of Resident #25 lying in their bed. Resident #25's hair was very disheveled and greasy. The resident was also noted to have facial hair approximately 1/16 inch long on both cheeks, the upper lip, and their chin. During an interview at that time Resident #25 stated he/she had received a shower on 05/29/2023, but staff did not shave them or wash their hair. On 05/31/2023 at 8:42 AM, Resident #25 stated staff had just given them a bed bath but did not offer to shave them or wash his/her hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/31/2023 at 11:44 AM, Certified Nursing Assistant (CNA) #12 stated she had been caring for Resident #25 and indicated the resident required total care with bathing and grooming. CNA #12 indicated she had not been able to wash the resident's hair, because she had not been able to get the resident to the shower due to the resident requiring a mechanical lift for transfers. CNA #12 said she would have had to get the big boat shower bed, which she indicated was located on the other side of the building. CNA #12 said she tried to use a washcloth during the resident's bed bath to remove the flakes from around their forehead and around their ears. CNA #12 also indicated she had not gotten around to shaving the resident, but said the razors were accessible and located on the hall. CNA #12 acknowledged Resident #25 needed their hair washed and to be shaved. CNA #12 was unsure how long it had been since Resident #25 was shaved. During an interview on 05/31/2023 at 11:54 AM, Licensed Practical Nurse (LPN) #13 said the day and evening shift provided resident's showers, provided hair care, and shaving. She indicated it was the nurse's responsibility to ensure that grooming and personal hygiene were provided. LPN #13 said if there was a problem with providing the care to residents, the CNAs should let the charge nurse know, so they could ensure that it got done. During an interview on 06/02/2023 at 11:26 AM, the Director of Nursing (DON) stated her expectation was for staff to provide ADL care for anything the residents were unable to do themselves. She also indicated that a resident should have access to showers/shampooing hair and said access to the big boat shower chair should not be a barrier to providing the care for the residents. During an interview on 6/02/2023 at 3:08 PM, the Administrator said his expectation was for staff to assist the patients as needed according to their care plans.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31524 Based on interviews, record review, and facility document review, the facility failed to refer a resident to dental services following complaints of tooth pain for one (Resident #57) of two sampled residents reviewed for dental services. Findings included: A review of an Admission Record indicated Resident #57 was admitted to the facility on [DATE] and readmitted on [DATE]. Further review revealed Resident #57 was their own responsible party (RP), with Medicaid as their primary payor source. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/2023, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A review of Resident #57's comprehensive care plans revealed no care plan addressing dental concerns or the need for dental services. A review of Resident #57's dental note, dated 03/25/2022, revealed Resident #57 was not seen for a comprehensive oral evaluation due to awaiting signed consents. Further review revealed a needed follow-up for a comprehensive oral evaluation to be done at a future visit on an undetermined date. During an interview on 05/30/2023 at 11:38 AM, Resident #57 stated they had tooth pain and had requested to see a dentist, but it had been over a year since they had last seen one. A review of a typed statement signed by the Administrator, dated 06/02/2023, indicated, It is our understanding that neither the patient [Resident #57] nor the family completed the necessary consents to obtain [dental] services. A review of email communication between the Social Services Director (SSD) and the dental providers, dated 06/01/2023, confirmed Resident #57 was not enrolled to receive dental services. During an interview on 06/02/2023 at 10:35 AM, Resident #57 said their tooth broke off on the right side about a year prior, causing pain, and they reported it to the facility at that time. Resident #57 stated they told Unit Manager #11 about their tooth pain most recently about three months ago and did not know he/she could tell any other staff member they needed to be seen by a dentist. Resident #57 stated they had not been asked to sign a consent to see the dentist and indicated he/she would have signed it if they had been asked. Resident #57 further stated they could eat normally and had not lost weight related to their broken tooth. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/02/2023 at 10:41 AM, the SSD stated the dentist came to the facility every other month to see residents. The SSD then stated he normally completed the resident's initial dental referral and then the business office became involved for payment. The SSD said if a resident needed to see a dentist, the nurses normally notified him, or the resident could tell him as well, and he got the process started. The SSD further stated Resident #57 had not seen the dentist since the initial paperwork noted in their chart, dated 03/25/2022, and he was not made aware of Resident #57's tooth pain until a few days ago. During an interview on 06/02/2023 at 11:00 AM, Unit Manager #11 stated Resident #57 had not told her about any recent tooth pain. According to Unit Manager #11, the last time Resident #57 verbalized mouth pain, it was related to their gums, not their tooth, and that was about a year ago. Unit Manager #11 stated she thought Resident #57 had seen a dentist since then and was on the list to see them soon. She further stated it was important for residents with gum or tooth pain to see a dentist to help alleviate the pain and to follow-up as needed for proper oral care. During an interview on 06/02/2023 at 11:25 AM, the Assistant Director of Nursing (ADON) stated if a resident verbalized any gum or tooth pain, nursing needed to notify the physician or the SSD to get an appointment set up with a dentist. The ADON said it was ultimately the unit manager's responsibility to notify the physician or the SSD to address the concern. The ADON then stated if there needed to be a signed consent, the family could sign it, or if the resident was alert and oriented, he/she could sign it prior to seeing the dentist. The ADON further stated it was important to follow up on any verbalized oral pain because the facility did not want residents to be in any pain. During an interview on 06/02/2023 at 12:15 PM, the Director of Nursing (DON) stated that when a resident verbalized any tooth or gum pain, she expected the nurses to notify the physician and to make any referrals as needed. The DON further stated the SSD assisted in setting up dental appointments and indicated if the resident was their own RP, they could sign the consent to be seen. The DON then stated it was important to follow up with a dentist on any dental complaints to ensure the resident could eat. During an interview on 06/02/2023 at 3:15 PM, the Administrator stated he expected the nursing staff to assess and address any resident complaints of dental pain. The Administrator further stated if a resident wanted to see a dentist for a concern, he expected a referral to be made.