STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. Building B. Wing	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrenceville Health & Rehabilitation	1722 Lawrenceville Plank Road Lawrenceville, VA 23868

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to ensure a wheelchair was clean and in safe condition for one of eighteen residents, Resident #3; and failed to ensure a homelike room environment on one of three units. Resident #3's wheelchair was dirty and with worn/torn cushions. Wall damage was observed in room [ROOM NUMBER]. The findings include: 1. Resident #3 was admitted to the facility with diagnoses that included atherosclerotic heart disease, COPD (chronic obstructive pulmonary disease), hypertension, gastroesophageal reflux disease, major depressive disorder, dementia, congestive heart failure and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed Resident #3 with severely impaired cognitive skills. On 3/16/22 at 9:34 a.m., Resident #3 was observed seated in a scoot type wheelchair near the nursing desk. The upper right side of the chair back was torn with foam visible. The left arm cushion was deteriorated. Crumbs, drips and lint were accumulated on the support bars under the seat. The rear of the seat cushion was covered with crumbs and debris. On 3/16/22 at 1:45 p.m., registered nurse (RN) #2 was interviewed about the condition of Resident #3's wheelchair. RN #2 stated the wheelchair seat cushion had a hole where the resident moved back and forth in the seat. RN #2 stated the wheelchairs were supposed to be cleaned on a regular basis. On 3/16/22 at 3:46 p.m., the director of nursing (DON) was interviewed about Resident #3's wheelchair. The DON stated she looked at the chair today and the armrest was worn with metal exposed. The DON stated the seat covering was also cracked from use. The DON stated she removed the chair from use due to safety concerns regarding the exposed metal on the armrest. This finding was reviewed with the administrator and director of nursing during a meeting on 3/16/22 at 4:30 p.m. 40027 2. On 03/15/2022 at 7:45 a.m., during the initial tour the drywall in the bathroom located in room [ROOM NUMBER] was observed in disrepair. The wall in the bathroom located near the baseboard had a section of drywall that was pushed in and had an uneven surface. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/16/2022 at 10:36 a.m., accompanied with the maintenance director (OS #2) in room [ROOM NUMBER], OS #2 was interviewed regarding the bathroom wall being in disrepair. OS #2 stated a couple of weeks earlier he had been made aware of a small area that needed repair in the bathroom; however the area was now larger. OS #2 stated, I think the roommate was ramming his wheelchair against the wall. He tends to do that a lot and that is why I have put the plastic/plexiglass material around the walls of the room. So I guess I will need to do the same for the bathroom. OS #2 was asked if there was a maintenance request system. OS #2 stated, We have a maintenance binder that I review 3 days per week. We also get information from the morning meetings. I don't think there was a maintenance request in the binder. I think I was told about the small area needing repair during the morning meeting. The above findings were reviewed with the administrator, director of nursing (DON), and corporate staff during a meeting on 03/16/2022 at 4:30 p.m. No additional information was provided to the survey team prior to exit on 03/17/2022 at 12:30 p.m.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on clinical record review, staff interview and during the course of a complaint investigation, the facility staff failed to develop and implement a baseline care plan for diabetes mellitus (DM) and pressure ulcers, for one of 18 residents in the survey sample, Resident #212. Findings include: Resident #212 was admitted to the facility with diagnoses included, but were not limited to: aftercare of left hip fracture with repair (arthroplasty), CHF (congestive heart failure), reflux, diabetes mellitus, hypothyroidism, atrial fibrillation, chronic obstructive pulmonary disease, high blood pressure, history of pneumonia, muscle weakness, and history of falls. The most current MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 13 indicating the resident was intact for daily decision making skills. Resident #212's clinical records were reviewed. A baseline care could not be found for Resident #212's immediate care for diabetes mellitus and pressure ulcers. On 03/16/22 at approximately 11:00 AM, the MDS coordinators licensed practical nurse (LPN) #2 and registered nurse (RN) #3, were interviewed regarding the baseline care plan for Resident #212 for diabetes and pressure ulcers. LPN #2 stated that the baseline care plans are on initially on paper. LPN #2 was made aware that Resident #212 had discharged from the facility on 11/17/21 and was asked if the initial care plan should have been scanned into the resident's EMR (electronic medical record). LPN #2 stated that it should have been scanned and would check with medical records and look for the baseline care plan for Resident #212. On 03/16/22 at approximately 2:30 PM, LPN #2 and RN #3 stated that a baseline care plan for Resident #212 in the areas of pressure ulcers and diabetes could not be found or had not been completed. No further information was provided prior to exit. This is a complaint deficiency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan (CCP) for two of 18 residents in the survey sample, Resident #7 and Resident #212. Resident #7's CCP did not include a focus area with goals and interventions for the use of the antianxiety medication, Buspirone; and Resident #212's CCP did not include a focus areas with goals and interventions for diabetes. The findings include: 1. Resident #7 was admitted to the facility with diagnoses that included anemia, cellulitis, muscle weakness, edema, and chronic obstructive pulmonary disease (COPD). The most recent minimum data set (MDS) dated [DATE] was a quarterly and assessed Resident #7 as cognitively intact for daily decision making with a score of 13 out of 15. Resident #7's electronic health record (EHR) was reviewed on 3/15/2022. Observed on the order summary report was the following: busPIRone HCl Tablet 5 MG (milligrams) Give 1 tablet by mouth two times a day for anxiety and depression. Order Date: 12/20/2021 Start Date: 12/20/2021. Resident #7's comprehensive care plans (CCP) were reviewed and did not include a focus area with goals and interventions for the use of the antianxiety medication, Buspirone. Resident #7's EHR consisted of a copy of a psychiatric evaluation dated 11/12/2021. Review of the evaluation documented the consult was for an evaluation of depression because Resident #7 reported anxiety. The psychiatric physician's plan documented: start Buspar (Buspirone) 5 mg 1 tab twice daily for anxiety and depression, monitor side effects and report changes. Encourage talking and f/u (follow up) 1-2 months . Resident #7 was interviewed on 03/15/2022 at 1:50 p.m. regarding his quality of care and quality of life since he was admitted to the facility. Resident #7 stated overall he liked being at the facility and everyone treated him nice. Resident #7 became tearful several times during the interview when he discussed his family and prior work history when he experience the lost of two coworkers while on the job. Resident #7 was asked if he needed to speak with the social worker. Resident #7 stated, No it's just a lot to think this will be my home. I get some kind of anxiety medication and that helps me. I saw my family yesterday and it's just hard when they leave. On 03/16/2022 at 9:34 a.m., the licensed practical nurse (LPN) #3 who routinely provided care for Resident #7 was interviewed regarding Resident #7's moods/behaviors and medications. LPN #3 reviewed Resident #7's EHR and stated, I've only been working here for 4 days. He does receive the Buspirone as scheduled. Sometimes he declines his breathing treatments, but other than that I haven't experienced him having moods or behaviors. He seems like a nice man. He enjoys going out smoking and watches television. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/16/2022 at 11:30 a.m., the MDS coordinator (LPN #2) who was responsible for care plans was interviewed regarding Resident #7's care plans not including a focus area for the use of the antianxiety medication Buspirone. LPN #2 stated she would review the record and follow-up with the survey team. On 03/16/2022 at 1:30 p.m., LPN #2 returned to the conference room and stated, I reviewed the record and the care plans should have been developed for the antianxiety medication use. The above findings were reviewed with the administrator, director of nursing (DON), and corporate staff during a meeting on 03/16/2022 at 4:30 p.m. No additional information was received by the survey team prior to exit on 03/17/2022 at 12:30 p.m. 27353 2. Resident #212 was admitted to the facility with diagnoses included, but were not limited to: aftercare of left hip fracture with repair (arthroplasty), CHF (congestive heart failure), reflux, diabetes mellitus, hypothyroidism, atrial fibrillation, chronic obstructive pulmonary disease, high blood pressure, history of pneumonia, muscle weakness, and history of falls. The most current MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 13 indicating the resident was intact for daily decision making skills. Resident #212's clinical records were reviewed. A progress note dated 11/17/21 documented that Resident #212's blood glucose level was checked and the result read, High. The resident's clinical records were further revealed Resident #212 had been on an oral hypoglycemic medication on admission, but do to the significant side effects from the medication, it was discontinued by the physician on 11/03/21. The resident's CCP was reviewed and there was no care plan for diabetes. On 03/16/22 at approximately 11:00 AM, the MDS coordinators licensed practical nurse (LPN) #2 and registered nurse (RN) #3, were interviewed regarding the diabetes care plan for Resident #212. LPN #2 stated that Resident #212 should have a care plan for diabetes, but would check with medical records. On 03/16/22 at approximately 2:30 PM, LPN #2 and RN #3 stated that a baseline care plan for Resident #212 in the area of diabetes was had not been created or could not be located. LPN #2 stated that the baseline care plan will usually carry over to the CCP, but Resident #212 didn't have one. LPN #2 stated that Resident #212 should have had a careplan for diabetes. No further information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for three of eighteen residents in the survey sample, Resident #3, #43, and #17. Resident #3's care plan was not updated to include use of a scoot type wheelchair and referenced a safety helmet that was no longer used. Resident #43's care plan was not revised regarding the discontinued use of a diuretic. Resident #17's plan of care reflected use of a feeding tube and Foley catheterthat were no long in place. The findings include: 1. Resident #3 was admitted to the facility with diagnoses that included atherosclerotic heart disease, COPD (chronic obstructive pulmonary disease), hypertension, gastroesophageal reflux disease, major depressive disorder, dementia, congestive heart failure and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed Resident #3 with severely impaired cognitive skills. On 3/16/22 at 9:34 a.m., Resident #3 was observed seated in a scoot type wheelchair near the nursing desk. The resident was not wearing a safety helmet. Resident #3's plan of care (revised 8/4/21) included no problems, goals and/or interventions regarding use of the scoot wheelchair. The care plan listed the resident was at risk of falls/injury due to history of falls, anti-anxiety medication use, confusion and limited mobility. Interventions to minimize fall/injury risk included, Safety Helmet while out of bed. The plan of care documented the resident at times refused to wear the safety helmet. Interventions to promote helmet use for safety included, Encourage resident to wear helmet .Educate resident on safety risks of not wearing helmet . On 3/16/22 at 1:49 p.m., registered nurse (RN) #2 was interviewed about Resident #3's care plan regarding the wheelchair and helmet. RN #2 stated she was not sure why the scoot wheelchair was not included in the care plan. RN #2 stated she had not seen Resident #3 wear a helmet in months. On 3/16/22 at 1:51 p.m., the certified nurses' aide (CNA) #1 that routinely cared for Resident #3 was interviewed. CNA #1 stated the resident had been in the scoot type wheelchair for quite a while. CNA #1 stated Resident #3 did not use a safety helmet. On 3/16/22 at 3:05 p.m., the licensed practical nurse (LPN) #2 responsible for MDS and care plan development was interviewed. LPN #2 stated the scoot chair had not been added to the care plan. LPN #2 stated the resident's use of the helmet had been discontinued and this intervention needed to be removed from the care plan. These findings were reviewed with the administrator and director of nursing during a meeting on 3/16/22 at 4:30 p.m. 09404 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident # 17 was admitted with diagnoses that included acute and chronic respiratory failure, anemia, coronary artery disease, congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, bipolar disorder, chronic obstructive pulmonary disease, dysphagia, generalized muscle weakness, PEG tube placement, and status post COVID-19. According to the most recent Minimum Data Set (MDS), a Quarterly review with an Assessment Reference Date of 1/15/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. At approximately 8:30 a.m. on 3/15/2022, Resident # 17 was observed in his room, sitting on the edge of his bed, with his breakfast tray on the overbed table in front of him. The resident was actively engaged in feeding himself. At approximately 9:00 a.m., after he completed breakfast, Resident # 17 was interviewed. Asked if he had a feeding tube, Resident # 17 said, I used to. He then lifted his shirt and pointed to a healing feeding tube entry point on his stomach. Resident # 17 went on to say they .took it out several weeks ago. Resident # 17's Electronic Health Record (EHR) included the following: 2/24/2022 - 3:38 p.m. - Nursing Progress Note - Resident returned from appointment with GI (Gastrointestinal) doctor. Peg tube removed without any problems. Orders given to place dry gauze dressing over site X (times) 3 days and change daily. Resident # 17's current care plan included the following problem, initiated on 11/29/2021, and revised on 12/6/2021, Mr. (Name of resident) requires a tube feeding r/t (related to) Dysphagia. The goal for the problem was, The resident will remain free of side effects or complications related to tube feeding through next review date. The interventions for the stated problem included, The resident needs the HOB (Head of Bed) elevated 45 degrees during and thirty minutes after tube feeding; Call MD when resident refuses tube feeding; Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed per MD orders; Listen to lung sounds every shift; Monitor/document/report PRN (as needed) any s/sx (signs, symptoms) of aspiration; Nurse to come back later and ask again to start tube feeding; Provide local care to G-Tube site as ordered and monitor for s/s of infection; RD (Registered Dietician) to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed; ST (Speech Therapy) evaluation and treatment as needed. At approximately 1:45 p.m. on 3/16/2022, licensed practical nurse (LPN) #2, who identified herself as processing Minimum Data Sets and Care Plans, was interviewed. Asked when a care plan should be modified or revised after a resident's change in condition, LPN # 2 said the care plan should be revised as soon as possible. Asked if two weeks was a reasonable time to revise a care plan, LPN # 2 indicated it was. Resident # 17's care plan also included the following problem, initiated on 11/29/2021, Mr. (Name of resident) has indwelling catheter. The goal for the problem included, The resident will show no s/sx (signs and symptoms) of Urinary infection through review date; The resident will be/remain free from catheter-related trauma through review date. Interventions for the stated problem included, Catheter: Position catheter bag and tubing below the level of the bladder and away from entrance room door; Check tubing for kinks each shift; Monitor for s/sx of discomfort on urination and frequency; Monitor/document for pain/discomfort due to catheter; Monitor/record/report to MD for s/sx UTI (Urinary Tract Infection). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident # 17's Quarterly MDS revealed at Section H (Bladder and Bowel), under Item H0100 (Appliances), the resident was assessed as not using any appliances, including indwelling catheter, external catheter, ostomy, or intermittent catheterization. During the interview and observation of Resident # 17 on 3/15/2022, there were no indicators of an indwelling catheter, including tubing or a collection bag. Resident # 17's Electronic Health Record (EHR) included the following: 12/10/2021 - Medication Administration Note - Status Post indwelling Foley Catheter removed, resident continues to urinate on his own without complication. During an end of day meeting at 4:00 p.m. on 3/16/2022, that included the Administrator, DON, corporate nurse consultant, and the survey team, the failure to review and revise Resident # 17's plan of care following the removal of his feeding tube and Foley catheter was discussed. 40027 3. Resident #43 was admitted to the facility with diagnoses that included schizoaffective disorder, mild intellectual disabilities, major depressive disorder, paranoid schizophrenia, mood disorder, hypertension, hyperlipidemia, and obesity. The most recent minimum data set (MDS) dated [DATE] was a quarterly and assessed Resident #43 as moderately impaired for daily decision making with a score of 11 out of 15. Resident #43's electronic health record (EHR) was reviewed on 03/15/2022. Observed Resident #43's care plan was the following focus area: The resident is on diuretic therapy (Lasix) r/t (related to) edema. Date Initiated: 07/24/2020: Revision: 07/24/2020 . A review of Resident #43's EHR did not document current orders for Lasix (Furosemide). Further review of the EHR documented the Furosemide 40 mg (milligrams) order was discontinued on 10/11/2021. On 03/16/2022 at 11:30 a.m., the MDS coordinator, licensed practical nurse (LPN) #2 who was responsible for care plans was interviewed regarding Resident #43's care plans showing Resident #43 was receiving Lasix (Furosemide). LPN #2 stated she would review the record and follow-up. On 03/16/2022 at 1:30 p.m., LPN #2 stated, I reviewed the record and she was taken off the Lasix so I discontinued that care plan. The above findings were reviewed with the administrator, director of nursing (DON), and corporate staff during a meeting on 03/16/2022 at 4:30 p.m. A review of the facility's Plans of Care Policies and Procedures (Revised: 9/25/2017) documented the following: .Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in the response to current interventions aft the completion of each OBRA MDS assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided to the survey team prior to exit on 03/17/2022 at 12:30 p.m.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure professional standards of practice for medication administration for one of 18 residents in the survey sample, Resident #40. Findings include: Resident #40 was admitted to the facility with diagnoses which included, but not limited to: acute/chronic kidney disease, Alzheimer's disease, diabetes mellitus, high blood pressure, chronic kidney disease and prostate cancer. The most current MDS (minimum data set) was a significant change assessment dated [DATE]. Resident #40 was assessed with a cognitive score of 3, indicating the resident had severe impairment in daily decision making skills. On 03/15/22 at 8:55 AM, a medication pass and pour observation was conducted with LPN (licensed practical nurse) #1. As LPN #1 prepared medications for administration, LPN #1 stated that she did not have the medication Flomax 0.4 mg (milligrams) for Resident #40 to administer. LPN #1 stated that she would call the pharmacy and have the medication delivered and would administer it upon arrival. At approximately 10:00 AM, a medication reconciliation for Resident #40 was completed. The resident's current orders were reviewed and included an order for, .Tamsulosin (Flomax) 0.4 mg Give 1 capsule by mouth one time a day for enlarged prostate (order date: 09/03/21) (start date: 09/04/21) . On 03/15/22 at 11:15 AM, LPN #1 was asked if the Flomax 0.4 mg for Resident #40 had arrived from the pharmacy and if the medication had been administered. LPN #1 stated that the medication had not arrived. LPN #1 stated that she had called the pharmacy and the pharmacy told her that they did not have a current order for the Flomax 0.4 mg for Resident #40. At 11:30 AM, LPN #1 called the pharmacy again. LPN #1 asked the pharmacy when the medication was last filled/dispensed and when it was sent to the facility. LPN #1 stated there was a current order for the Flomax in Resident #40's record. The pharmacy stated that a 30 day supply was last sent on 12/30/21 and stated that the medication had been discontinued on 01/19/22. LPN #1 stated then that Resident #40 had gone out to the hospital on January 19th and was readmitted on [DATE], and that was probably why the medication was discontinued. LPN #1 stated that someone may have put the order back in the system. The resident's CCP (comprehensive care plan) was reviewed and documented, .alteration in bladder incontinence (date initiated: 09/16/21) .neurogenic disorder .encourage fluids .monitor for signs/symptoms of UTI (urinary tract infection) .monitor/document/report as needed possible causes of incontinence . Resident #40's MAR (medication administration record) was reviewed and revealed that the resident had not received the Flomax 0.4 mg on March 7th, 9th, 10th, 14th and 15th (day of medication pass observation) due to the medication not being available for administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/15/22 at 3:15 PM, LPN #4 was interviewed regarding the Flomax for Resident #40. LPN #4 stated that she did not give the medication to Resident #40 because it was not there to give. LPN #4 stated that Resident #40 did not get the medicine on March 7th, 8th, and 9th from her (the days she worked). LPN #4 was made aware that she had signed her initials on 03/08/22 indicating the medication had been given. LPN #4 stated that must have been accidental and stated that Resident #40 did not receive Flomax on the three days that she worked (March 7th, 8th or 9th). On 03/16/22 at approximately 10:00 AM, the consultant pharmacist was interviewed regarding Resident #40's Flomax order. The pharmacist stated that medications are automatically discontinued when a resident goes to the hospital and could not explain why Resident #40 still had a current order showing in the clinical record. The pharmacist stated that the facility may have had some medication (Flomax) left or a slight overage from ordering early, but stated that there is no way the facility had enough medication to get them all the way through March 15th. The pharmacist stated that there are two Flomax 0.4 mg pills in the stat box, but that is all. On 03/16/22 at approximately 3:30 PM, LPN #1 was interviewed again regarding Resident #40's Flomax. LPN #1 was made aware of the discrepancy between when the pharmacy last delivered a 30 day supply of the medication on 12/30/22, that it was being documented that Resident #40 was getting the medication, when the resident's 30 day supply should have been exhausted. LPN #1 had documented multiple times that the medication was given and was asked how a medication can be administered when the medication is not available to give. LPN #1 stated, I would have borrowed it, I know that's illegal, but if I signed I gave it, I gave it. LPN #1 was asked how many days she borrowed medication. LPN #1 could not provide an answer. LPN #1 stated that she did not take the time to call the pharmacy or pull a sticker to reorder the medication for Resident #40. On 03/16/22 at approximately 4:00 PM, the administrator and DON were made aware of the above information in a meeting with the survey team. The DON stated that staff are not supposed to borrow medications from other residents. A policy was requested on administering medications per physician's orders and borrowing medications from other residents. A policy titled, Administering Medications was presented and reviewed. The policy documented, .Medications are administered in accordance with the prescriber orders .medications ordered for a particular resident may not be administered to another resident . No further information and/or documentation was presented prior to the exit conference on 03/17/22.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for two of 18 residents in the survey sample, Resident #40 and Resident #212. Resident #40 was not administered medication (Flomax) as ordered by the physician. Resident #212 was on a physician ordered fluid restriction, but there were no fluid intake records for this resident. Findings include: 1. Resident #40 was admitted to the facility with diagnoses which included, but not limited to: acute/chronic kidney disease, Alzheimer's disease, diabetes mellitus, high blood pressure, chronic kidney disease and prostate cancer. The most current MDS (minimum data set) was a significant change assessment dated [DATE]. Resident #40 was assessed with a cognitive score of 3, indicating the resident had severe impairment in daily decision making skills. On 03/15/22 at 8:55 AM, a medication pass and pour observation was conducted with LPN (licensed practical nurse) #1. As LPN #1 prepared medications for administration, LPN #1 stated that she did not have the medication Flomax 0.4 mg (milligrams) for Resident #40 to administer. LPN #1 stated that she would call the pharmacy and have the medication delivered and would administer it upon arrival. At approximately 10:00 AM, a medication reconciliation for Resident #40 was completed. The resident's current orders were reviewed and included an order for, .Tamsulosin (Flomax) 0.4 mg Give 1 capsule by mouth one time a day for enlarged prostate (order date: 09/03/21) (start date: 09/04/21) . On 03/15/22 at 11:15 AM, LPN #1 was asked if the Flomax 0.4 mg for Resident #40 had arrived from the pharmacy and if the medication had been administered. LPN #1 stated that the medication had not arrived. LPN #1 stated that she had called the pharmacy and the pharmacy told her that they did not have a current order for the Flomax 0.4 mg for Resident #40. At 11:30 AM, LPN #1 called the pharmacy again. LPN #1 asked the pharmacy when the medication was last filled/dispensed and when it was sent to the facility. LPN #1 stated there was a current order for the Flomax in Resident #40's record. The pharmacy stated that a 30 day supply was last sent on 12/30/21 and stated that the medication had been discontinued on 01/19/22. LPN #1 stated then that Resident #40 had gone out to the hospital on January 19th and was readmitted on [DATE], and that was probably why the medication was discontinued. LPN #1 stated that someone may have put the order back in the system. The resident's CCP (comprehensive care plan) was reviewed and documented, .alteration in bladder incontinence (date initiated: 09/16/21) .neurogenic disorder .encourage fluids .monitor for signs/symptoms of UTI (urinary tract infection) .monitor/document/report as needed possible causes of incontinence . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40's MAR (medication administration record) was reviewed and revealed that the resident had not received the Flomax 0.4 mg on March 7th, 9th, 10th, 14th and 15th (day of medication pass observation) due to the medication not being available for administration. On 03/15/22 at 3:15 PM, LPN #4 was interviewed regarding the Flomax for Resident #40. LPN #4 stated that she did not give the medication to Resident #40 because it was not there to give. LPN #4 stated that Resident #40 did not get the medicine on March 7th, 8th, and 9th from her (the days she worked). LPN #4 was made aware that she had signed her initials on 03/08/22 indicating the medication had been given. LPN #4 stated that must have been accidental and stated that Resident #40 did not receive Flomax on the three days that she worked (March 7th, 8th or 9th). On 03/16/22 at approximately 3:30 PM, LPN #1 was interviewed again regarding Resident #40's Flomax. LPN #1 was made aware of the discrepancy between when the pharmacy last delivered a 30 day supply of the medication on 12/30/22, that it was being documented that Resident #40 was getting the medication, when the resident's 30 day supply should have been exhausted. LPN #1 had documented multiple times that the medication was given and was asked how a medication can be administered when the medication is not available to give. LPN #1 stated, I would have borrowed it, I know that's illegal, but if I signed I gave it, I gave it. LPN #1 was asked how many days she borrowed medication. LPN #1 could not provide an answer. LPN #1 stated that she did not take the time to call the pharmacy or pull a sticker to reorder the medication for Resident #40. On 03/16/22 at approximately 4:00 PM, the administrator and director of nursing (DON) were made aware of the above information in a meeting with the survey team. A policy was requested on administering medications per the physician's order. A policy titled, Administering Medications documented, .Medications are administered in accordance with the prescriber orders .medications ordered for a particular resident may not be administered to another resident . On 03/16/22 at approximately 5:00 PM, the DON and administrator were again made aware of the above information and concerns regarding Resident #40 not receiving his physician ordered Flomax from March 7th through March 10th and on March 14th and 15th. No further information and/or documentation was presented prior to the exit conference on 03/17/22. 2. Resident #212 was admitted to the facility with diagnoses which included, but were not limited to: aftercare of left hip fracture with repair (arthroplasty), CHF (congestive heart failure), reflux, diabetes mellitus, hypothyroidism, atrial fibrillation, chronic obstructive pulmonary disease, high blood pressure, history of pneumonia, muscle weakness, and history of falls. The most current MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 13 indicating the resident was intact for daily decision making skills. Resident #212's physician's orders were reviewed. The resident had an order dated 10/26/21 for, 1 Liter fluid restriction daily related to CHF . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's MARs/TARs (medication administration records/treatment administration records) were reviewed. No fluid intake records were located. Resident #212's CNA (certified nursing assistant) documentation was reviewed for fluid intake. No records were found to evidence that the resident's fluid intake was being documented. The resident's CCP (comprehensive care plan) documented, .has potential fluid volume overload related to heart failure (date initiated: 11/03/21) .administer medications as ordered .diet as ordered .ensure all snacks and beverages offered .comply with diet and fluid restrictions .Monitor/document/report as needed any signs/symptoms of fluid overload . On 03/16/22 at approximately 5:00 PM, the administrator and director of nursing (DON) were made aware of the above concerns regarding Resident #212 having CHF, being ordered a fluid restriction on admission, and that no fluid intake records were found. The DON stated that she would look for them. The DON stated that they normally get an order and it will carry over to the MAR/TAR and they will document each shift the amount of fluid taken by the resident. The DON stated that it is usually divided out for a certain amount of fluid for each shift. On 03/17/22 at 10:55 AM, the DON stated that they did not have any intake records for Resident #212. No further information and/or documetnation was presented prior to the exit conference on 03/17/22.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on clinical record review, staff interview, facility document review, and during the course of a complaint investigation, the facility staff failed to assess and implement interventions for the treatment and prevention of pressure ulcers for one of 18 residents in the survey sample, Resident #212. Findings include: Resident #212 was admitted to the facility with diagnoses which included, but were not limited to: aftercare of left hip fracture with repair (arthroplasty), CHF (congestive heart failure), reflux, diabetes mellitus, hypothyroidism, atrial fibrillation, chronic obstructive pulmonary disease, high blood pressure, history of pneumonia, muscle weakness, and history of falls. The most current MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 13 indicating the resident was intact for daily decision making skills. The resident was also assessed as requiring extensive assistance from at least two staff members for most ADL's (activities of daily living), including: transfers, bed mobility, dressing, toileting, and bathing. The resident was assessed as having one unhealed pressure area that was present upon admission. Resident #212's clinical records were reviewed. An admission assessment dated [DATE] at 2:00 PM documented, .Skin for every resident complete Braden scale for predicting pressure sore risk .if skin impairment noted-initiate skin grid (pressure or non-pressure) .right buttock - open area .right toe - right great toe .admitted to facility .left hip fracture .great toe of right foot had reddened area to tip of toe. Open area noted to right inner buttock . There were no measurements or any other description of the open and reddened areas than what is listed above. A nursing skin/wound assessment for Resident #212 could not be located for the above identified areas. On 10/28/21 Resident #212 was seen by the wound doctor for the buttock wound. There was no documentation regarding the resident's toes or feet. A progress note dated 11/03/21 at 7:06 PM documented, .bilateral heel DTI (deep tissue injury) .bilateral heels floated in bed . No skin or wound assessment was found for the bilateral heel DTI. A nursing progress note dated 11/08/21 and timed 6:40 PM documented, .sacrum open area treatment in place . There was no wound assessment by nursing to describe the appearance of the wound or the size of the wound. On 11/11/21 at 1:27 PM, a nursing progress note documented, .sacral wound treatment in place . No nursing wound assessment was found to determine the wound size, characteristics, progression and/or deterioration. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/21 at 12:10 PM, a nursing progress note documented, .foul odor noted from sacrum wound .call (Name of attending physician) . There was no wound assessment information or documentation regarding the wound, other than the foul odor. According to progress notes, Resident #212 was sent out to the hospital for evaluation of the wound and concerns regarding infection. A baseline care could not be found for Resident #212's immediate care for pressure ulcers. Resident #212's CCP (comprehensive care plan) documented, .has pressure injury to sacrum .(date initiated: 11/03/21) . administer treatments as ordered (11/03/21) .assess, record and monitor wound healing (11/03/21) .weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (11/03/21) . On 03/16/22 at approximately 2:30 PM, the MDS coordinators licensed practical nurse (LPN) #2 and registered nurse (RN) #3, stated that a baseline care plan for Resident #212 for pressure ulcers could not be found or had not been completed. On 03/16/22 at approximately 5:00 PM, the DON (director of nursing) and the administrator were made aware of the above information regarding Resident #212's lack of assessment by nursing on admission. The DON was made aware of the lack of interventions for the prevention of pressure areas on admission when Resident #212 was identified as high risk for pressure concerns, and had skin impairment on admission. On 03/17/21 at 9:45 AM, Resident #212's physician was interviewed and made aware that Resident #212 did not have a baseline care plan and there was lack of interventions to prevent pressure ulcers, when Resident #212 had been identified as a high risk for pressure related problems. The physician stated that Resident #212 was a complicated diabetic and had multiple comorbitities, but stated that he thought that there was a protocol in place to identify and implement interventions upon admission. A policy/protocol titled, Clinical Guidelines Skin &Wound documented, .provide a system of for identifying skin at risk, implementing individual interventions, including evaluation and monitoring .to promote skin health and decrease worsening of/prevention of pressure injury .On admission .the resident's skin will be evaluated for baseline skin condition and document in the medical record .Licensed nurse to complete skin evaluations weekly .document in medical record .CNA to complete skin observations and report to Licensed Nurse .Licensed Nurse to document presence of skin impairment/new skin impairment when observed weekly .report changes to .physician .develop individualized goals and interventions and document on care plan .weekly skin evaluations .incontinence care, reposition frequently, relieve and protect heel pressure . monitor nutrition and hydration trends . On 03/17/21 at 10:55 AM, the DON was made aware that nursing staff failed to follow Resident #212's CCP for wound assessment documentation and failed to follow their wound protocol. The DON was asked what initial interventions should have been implemented for Resident #212. The DON stated, I would have floated the heels, turned and repositioned, sure prep if the area isn't open. The DON was made aware that the initial admission assessment was completed by an LPN and that there was no other assessment information. The DON stated that a RN is supposed to follow up on assessments completed by LPNs and stated that the facility is starting to do that now. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information and/or documentation was presented prior to the exit conference on 03/17/22. This is a complaint deficiency.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 27353 Based on medication pass and pour observation, staff interview, and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 percent. The total number of opportunities were 35, with a total of 4 medication errors, which resulted in a medication error rate of 11.43 percent. Findings include: 1. On 03/15/22 at 8:56 AM, LPN (Licensed Practical Nurse) #1 prepared medications for Resident #40. LPN #1 pulled the resident's medications and put them into a plastic medication cup. The medications were documented and then counted for accuracy. The count did not match. The medications in the cup were 12 pills; the number of pills documented was 10. LPN #1 was asked to pull each medication pill card/bottle from the medication cart. The pill cards/bottles were compared to the pills in the cup, as well as, what was documented. Each pill card had the pill's identifying characteristics listed. LPN #1 stated that she had pulled two of the famotidine pills (20 mg each) and stated the resident is ordered 40 mg. This made the count 11. LPN #1 stated that she also pulled a folic acid pill, which would then make the count 12. As a result of the above information, each medication in the cup was verified with the pill identifying characteristics listed on the medication card or bottle. All were correct except one white pill. LPN #1 stated that the last pill in the cup was the Norvasc 5 mg tablet. The pill in the cup did not match the pill in the Norvasc 5 mg card and did not match the identifying characteristics listed on the card for Norvasc 5 mg. LPN #1 then stated that she did not know, but felt certain the pill should be the Norvasc 5 mg tablet. The pill in the cup was again compared to the pill in the Norvasc 5 mg card. LPN #1 then stated, That isn't the same pill. The pill in the cup was white, scored on one side, and had the imprint PLIVA 434. This pill was identified as a Trazadone 100 mg tablet. LPN #1 had pulled the incorrect mediation for administration. The Norvasc 5 mg pill that was ordered to be given at this time was not put in the cup for administration. LPN #1 was asked what she thought may have happened. LPN #1 stated that the Trazadone is a night time medication and she didn't pull any of those cards out. LPN #1 then stated that when she pulled the Norvasc 5 mg card out of the drawer, the first one was empty and the one behind it must have been the Trazadone card. LPN #1 stated, I must not have paid attention to that. LPN #1 had another card of the Norvasc 5 mg tablets, but no pills had been removed from the card, it was full. LPN #1 stated that Resident #40 was also supposed to get a tamsulosin (Flomax) 0.4 mg capsule, but that the medication was not available, and she would have to call the pharmacy and have it delivered and would administer it when it arrived. LPN #1 stated, .That's a med error. LPN #1 was made aware that the omission of the Norvasc 5 mg tablet and the addition of the Trazadone 100 mg tablet would count as two medication errors. A medication reconciliation was completed for Resident #40. The current physician's orders were: . Tamsulosin HCL capsule 0.4 mg give 1 capsule by mouth one time a day for enlarged prostate (9:00 AM) . amlodipine (Norvasc) tablet 5 mg give one tablet by mouth one time a day (9:00 AM) .Trazadone 100 mg give one tablet by mouth one time a day (9:00 PM) . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/15/22 at 11:30 AM, LPN #1 was asked about the Flomax medication. LPN #1 stated that she had called the pharmacy and that they told her that the medication was not showing up as an active order in the system. LPN #1 was made aware that the resident's physician's orders and the resident's MAR (medication administration record) both listed the the Flomax 0.4 mg capsule as a current medication for Resident #40 to be administered at 9:00 AM. LPN #1 stated that when she called the pharmacy they told her that they did not have a current order for the Floxmax 0.4 mg for Resident #40, but she knew it was a current order. At approximately 12:00 PM, LPN #1 was made aware that the due to the medication Flomax not being administered per the physician's order that would also count as a medication error. On 03/16/22 at 5:00 PM, the administrator and DON were made aware of the above medication errors. No further information and/or documetnation was presented prior to the exit conference on 03/17/22. 21875 2. A medication pass was conducted on 3/15/22 at 8:34 a.m. with licensed practical nurse (LPN) #4 administering medications to Resident #32. Included in medications administered to Resident #32 was losartan potassium 25 mg (milligrams). Resident #32's clinical record documented a physician's order dated 3/2/22 for lorsartan potassium 50 mg each day for treatment of hypertension. The resident had no current order for a 25 mg dose of losartan potassium. On 3/15/22 at 10:00 a.m., LPN #4 was interviewed about the lorsartan potassium 25 mg administered to Resident #32. LPN #4 reviewed the current physician orders and stated the order was for a 50 mg dose. LPN #4 pulled the pharmacy supply card of losartan potassium used during the medication pass. The pharmacy label indicated the lorsartan potassium was 25 mg. LPN #4 looked through the medication cart and stated she did not see a supply card for a 50 mg dose. On 3/15/22 at 3:45 p.m., the unit manager (LPN #5) was interviewed about the medication error observed with Resident #32. LPN #5 looked through the medication cart and located a supply card with losartan potassium 50 mg tablets. LPN #5 stated the 50 mg dose was available and should have been given as ordered. The policy titled, .general dose preparation of medication administration documented, .Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time for the correct resident . This finding was reviewed with the administrator and director of nursing during a meeting on 3/15/22 at 4:30 p.m.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to label medication accurately for one of eighteen residents in the survey sample, Resident #32. Resident #32 had four pharmacy supplied cards of lorsartan potassium 25 mg (milligrams) available for use in the medication cart with no label indicating a dosage change to 50 mg. The findings include: Resident #32 was admitted to the facility with diagnoses that included hypertension, hypercholesterolemia, morbid obesity, aphasia and dementia. The minimum data set (MDS) dated [DATE] assessed Resident #32 with severely impaired cognitive skills. A medication pass was conducted on 3/15/22 at 8:34 a.m. with licensed practical nurse (LPN) #4 administering medications to Resident #32. Included in medications administered to Resident #32 was losartan potassium 25 mg (milligrams). Resident #32's clinical record documented a physician's order dated 8/13/21 for lorsartan potassium 25 mg each day for treatment of hypertension. The order was changed on 3/2/22 requiring lorsartan potassium 50 mg each day. On 3/15/22 at 10:00 a.m., LPN #4 was interviewed about the lorsartan potassium 25 mg administered to Resident #32. LPN #4 reviewed the current physician orders and stated the current order was for a 50 mg dose. LPN #4 pulled the pharmacy supply card of losartan potassium used during the medication pass. The pharmacy label indicated the lorsartan potassium was 25 mg. LPN #4 looked through the medication cart and stated she did not see a supply card for the 50 mg. There was no label on the 25 mg supply card of losartan potassium indicating a dosage change. On 3/15/22 at 3:45 p.m., the unit manager (LPN #5) was interviewed about the medication error observed with Resident #32. LPN #5 looked through the medication cart and located a supply card with thirty tablets of losartan potassium 50 mg. Upon further review of the medication cart, LPN #5 located three additional cards of losartan potassium 25 mg labeled for Resident #32. There was no sticker or any identification on the labels indicating a dosage change to 50 mg. One card had five tablets remaining, one card had one tablet remaining and a third card had six tablets remaining. The card used during the medication pass on no tablets left. On 3/15/22 at 3:22 p.m., the facility's consultant pharmacist (other staff #1) was interviewed about the four supply cards of losartan potassium 25 mg stored in the medication cart. The pharmacist stated the losartan potassium 50 mg was dispensed to the facility on [DATE]. The pharmacist stated it was possible to use two of the 25 mg tablets for the 50 mg dose but pharmacy was required to communicate that to nursing and indicate such on the medication label. The pharmacist stated nursing could apply a sticker to the label on the 25 mg tablets indicating the dosage had been changed but only if instructed by the pharmacy. The pharmacist stated he did not know if pharmacy communicated to nursing about the label/dosage change. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Reordering, Changing, and Discontinuing Orders (revised 1/1/22) documented, .Any request to change an existing order should be treated by Facility as a new order, with a corresponding cancellation of the previous order .If Pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand .Pharmacy should discontinue the original order .Facility Physician/Prescriber should write the new order with new directions and Facility should enter the new order on the appropriate Medication Record Forms; and .If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication and attach a 'Change in Directions' sticker to the existing quantity of medications . This finding was reviewed with the administrator and director of nursing during a meeting on 3/15/22 at 4:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. Building B. Wing	03/17/2022

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on staff interview and clinical record review, the facility staff failed to ensure physician ordered laboratory services were obtained for 2 of 18 residents in the survey sample, Resident #43 and Resident #40. Depakote levels were not obtained for Resident #43. The facility failed to process a urine sample timely for Resident #40. The findings include: 1. Resident #43 was admitted with diagnoses that included schizoaffective disorder, mild intellectual disabilities, major depressive disorder, paranoid schizophrenia, mood disorder, hypertension, hyperlipidemia, and obesity. The most recent minimum data set (MDS) dated [DATE] was a quarterly and assessed Resident #43 as moderately impaired for daily decision making with a score of 11 out of 15. Resident #43's electronic health record (EHR) was reviewed on 03/15/2022. Observed on the order summary report was the following: depakote level every night shift every 5 month(s) starting on the 18th for 1 day(s) related to PARANOID SCHIZOPHRENIA (F20.0) Order Date: 10/17/2020 Start Date: 10/18/2020. Based on the physician orders, the Depakote levels were due on March 18, 2021, August 18, 2021, and January 18, 2022 during the survey look back period. A review of Resident #43's treatment administration records (TAR) for the period of October 2020 through March 2022 did not document the labs were completed in March 2021 and August 2021. An eMar (electronic medication administration record) progress note dated 1/19/2022 documented: Resident refused blood work for the January 18, 2022 labs. A review of Resident #43's EHR did not include the laboratory results for the Depakote levels for March 18, 2021 and August 18, 2021. The EHR consisted of a copy of Valproic Acid (Depakote) lab levels was completed on 09/30/2020. On 03/16/2022 at 3:10 p.m., the administrator and director of nursing (DON) were interviewed regarding the missing labs. The DON reviewed Resident #43's and stated she was only able to locate the 9/30/2020 lab results. The DON stated, I reviewed the (lab provider) online and did not locate the labs for March 2021 or August 2021. The DON was asked about the process for the lab orders. The DON stated the orders are placed in a lab binder and the nurse reviews the TAR each morning and then matches/verifies the order in the lab binder to make sure the lab is aware they must come in to draw the labs. The DON stated based on her review of the TAR, the labs may not have been requested. The above findings were reviewed with the administrator, DON, and corporate staff during a meeting on 03/16/2022 at 4:26 p.m. No additional information was provided to the survey team prior to exit on 03/17/2022 at 12:30 p.m. 09404 (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident # 40 was admitted with diagnoses that included malignant neoplasm of the prostate, anemia, hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, hyperlipidemia, Alzheimer's Disease, seizure disorder, schizophrenia, chronic obstructive pulmonary disease, difficulty walking, generalized muscle weakness, irritable bowel syndrome, chronic kidney disease, Sickle Cell disease, and status post COVID-19. According to the most recent Minimum Data Set, a Significant Change, with an Assessment Reference Date of 2/2/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively impaired, with a Summary Score of 03 out of 15. Under Section H (Bladder and Bowel), the resident was assessed as frequently incontinent of bladder and bowel. The Progress Notes in the resident's Electronic Health Record included the following: 3/9/2022 - 12:32 p.m. - Nursing Progress Note - Report from previous shift indicated that res (resident) c/o (complained of) having the urge to urinate but being unable to 3/9/2022 - 12:48 p.m. - Nursing Progress Note - SN (Shift Nurse) spoke with MD (name) office to inform of report of res urgency without urination. MD gave verbal phone order for UA C&S (Urinalysis Culture and Sensitivity). Clean urinal given to res with instructions for a clean catch urine sample. 3/10/2022 - 6:32 a.m. - Nursing Progress Note - Clean catch urine specimen obtained for C&S per MD orders. 3/14/2022 - 1:15 p.m. - Nursing Progress Note - Received call this shift from Lab. Res had urine sent to lab for UA C&S. According to the lab, the date on the urine was 3/10/22. Lab unable to process sample due to collection date being over 24 hours ago. Lab states urine needs to be recollected and a new order needed to be put in. SN put new order for UA C&S collection to be on third shift today, 3/14/22. MD office notified of change. At approximately 10:30 a.m. on 3/16/2022, the Director of Nursing (DON) was asked why the urine sample did not get to the lab on time. The DON stated that lab specimens are put out for lab pick-up and that the lab comes by around 6:00 a.m., and sometimes earlier, except for weekends. The following entry was also included in the Progress Notes: 3/16/2022 - 2:49 p.m. - Nursing Progress Note - Attempts made to collect urine for analysis this shift, resident continent and has gone to bathroom independently, resident has been asked to please ring call light when he feels urge to urinate, made him aware of need for specimen During an end of day meeting at 4:30 p.m. on 3/16/2022, that included the Administrator, DON, corporate nurse consultant, and the survey team, the collection of the urine sample from Resident # 40 was discussed. Asked if the sample obtained that day, 3/16/2022, was the sample ordered on 3/14/2022. the DON said, Yes, I personally saw the sample. The DON went on to say, We have three days to obtain the sample. There was no further discussion regarding the urine sample.