STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaufont Health and Rehabilitation Center	200 Hioaks Road Richmond, VA 23225

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49917 Based on information obtained during resident group interview and staff interviews the facility staff failed to assist 3 residents (#17, #1, and #27) to exercise their right to vote in the November 2023 general election in the survey sample of 50 residents. The findings included: 1. The facility failed to remind and assist Resident #17, to vote in the November 2023 general election. Resident #17 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus without complications, muscle weakness, and constipation. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/16/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #17's cognitive abilities for daily decision making were intact. On 5/7/24 at approximately 1:00 PM, an interview was conducted with the Resident Council group. During this interview Resident #17 stated he didn't get to vote in the November 2023 election, and it was his desire to vote. The resident stated that no one talked about the upcoming election or asked if he wanted or needed assistance to obtain an absentee ballot. 2. The facility failed to remind and assist Resident #1, to vote in the November 2023 general election. Resident # 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, muscle weakness, type 2 diabetes mellitus without complications, and hyperlipidemia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/4/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. (continued on next page)

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

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: 495260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at approximately 1:00 PM, an interview was conducted with the Resident Council group. During this interview Resident #1 stated she didn't get to vote in the November 2023 election, and it was her desire to vote. The resident stated that no one talked about the upcoming election or asked if she wanted or needed assistance to participate in the November 2023 election. 3. The facility failed to remind and assist Resident #27, to vote in the November 2023 general election. Resident #27 was originally admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, acquired absence of right leg above knee, acquired absence of left leg above knee, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were intact. On 5/7/24 at approximately 1:00 PM, an interview was conducted with the Resident Council group. During this interview Resident #27 stated he didn't get to vote in the November 2023 election, and he would have liked to vote. The resident stated that no one talked about the upcoming election or asked if he wanted or needed assistance to obtain an absentee ballot. An interview was conducted with the Activities Director on 5/14/24 at 12:55 PM. The Activities Director stated that the residents did not have an opportunity to vote in the November 2023 general election and it is her duty to manage all voting activities. The Activities Director also stated going forward she would ensure all activities related to voting are carried out. An interview was conducted with the Administrator on 5/14/24 at 1:05 PM. The Administrator stated that he understands the importance of residents voting however he cannot produce any evidence that residents had the opportunity to vote in the November 2023 general election. On 5/14/24 at approximately 3:45 PM, a final interview was conducted with the Administrator, Assistant Administrator, Regional Nurse Consultant, and Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49455 On 5/14/24 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. Based on observations, resident interviews, staff interviews, family interview, and clinical record review, the facility staff failed to inform, educate, formulate, and document information concerning the right to have an advanced directive for 2 of 50 residents in the survey sample, Resident #106, and Resident #55. The findings include: 1. On admission the facility staff failed to inform and educate Resident #106 about advanced directives. The facility staff failed to assist in helping the resident to formulate an advanced directive if she would have wanted one. The facility staff failed to document in the progress notes any interaction to support that they provided any of the above to Resident #106. The facility failed to document that the resident refused any advance directive services if that would have been her decision. Resident #106 was originally admitted to the facility on [DATE] and readmitted on [DATE] after an acute care hospital stay. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/26/24 coded the Resident #106 as completing the Brief Interview for Mental Status (BIMS) and scoring 15 which indicated the resident was cognitively intact. Resident #106's personal centered care plan created on 1/23/24 had an updated entry dated 3/24/24 that read, the resident has an advanced directive of full code. There was no documentation in the resident's medical record that supports a conversation with the resident to come to that decision. An interview was conducted with Resident #106 and Family Member (FM) #1 on 5/7/24 at approximately 11:45 AM. They both denied having any conversation with any facility staff on Advanced Directives. An interview was conducted with the Director of Social Work on 5/7/24 at approximately 1:00 PM, who shared that advanced directives should be initiated by the admitting nurse. She said advance directive questions were included in the admission process and could be found in the resident's medical record under documents and should be titled admission packet. The Director of Social Work looked in Resident #106 medical records and shared that she could not find the advanced directive documents from the resident's admission process. An interview was conducted with the Administrator on 5/13/24 at approximately 4:00 PM, who shared the facilities policy on advanced directive, as well as the facility's protocol Medical Facilities of America (MFA) policies governing the implementation of self-determination rights. The administrator said that this document should be under documents in the resident record and any conversations had about advanced directives should be documented in progress notes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #106 medical record was reviewed. There were no progress notes supporting the resident received any information on advanced directives. The resident's admission packets dated 12/19/23 and 1/17/24 were reviewed and the policy on advanced directive, as well as the facility's protocol/policies governing the implementation of self-determination rights were not found. There was no admission packet for the resident's most recent admission of 2/6/24. The facility's policy titled Advanced Directives, effective 1/6/20 read, . Social Work and Discharge Planning staff will assist with requests for information regarding Advance Directives upon patient's admission to the Center and throughout the patient's stay to allow each patient an opportunity to plan in advance for medical treatment . The facility's protocol/policies governing the implementation of self-determination rights is a document that the Administrator, Regional Nurse Consultant, and Director of Social Work should have been used on admission, completed, and placed in the resident's medical record. This form has check boxes for the resident to make as proof of receiving the document, being educated verbally as well as being given written information on advanced directives, being offered assistance to formulate an advanced directive, and a place to refuse wanting an advance directive. This could not be found in Resident #106's medical record by the Director of Social Services. An advance directive, sometimes called a living will, is a written document that tells your healthcare providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself. This information is important if you become unconscious or otherwise too sick to make your wishes known. (https://www.hopkinsmedicine.org/patient-care/patients-visitors/advance-directives) On 5/14/24 at approximately 3:30 p.m., the above findings were reviewed with the Administrator, Director of Nursing, and Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 40711 2. For Resident #55 the facility staff failed to formulate an advance directive. Resident #55 was originally admitted to the facility on [DATE] after an acute care hospital stay. The current diagnoses included essential hypertension. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 01/26/2024 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of a possible 15. This indicated Resident #55 cognitive abilities for daily decision making were severely impaired. In sectionGG(functional abilities and goals) the resident was coded as requiring set-up help with eating and oral hygiene, requiring partial/moderate assistance with toileting hygiene and personal hygiene and substantial/maximal assistance with bathing/showering. A review of the Resident's clinical record revealed no advanced directive was available. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/14/24 at approximately 9:57 AM., with the Social Worker (SW). The SW said that the Advanced Directed was not available in the medical chart. The SW also said that the advance directive should have been offered to the resident during admission. On 5/14/24 at approximately 3:30 p.m., the above findings were reviewed with the Administrator, Director of Nursing and Regional Nurse Consultant. The administrator said that the admissions coordinator would discuss the advanced directive and provide education.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, family interview, staff interview, clinical record review, a review of facility documents, the facility's staff failed to notify family of an abnormal lab and transfer to a local hospital for 1 of 50 (Resident #172), a closed record resident. The findings included: Resident #172 was originally admitted to the facility 05/27/2022 and discharged on [DATE]. The current diagnoses included but was not limited to acute kidney failure. The entry Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 06/02/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #172 cognitive abilities for daily decision making were moderately impaired. The Discharge Minimum Data Set (MDS) assessment with an assessment reference date of 6/02/22 coded resident discharged with return anticipated. In sectionGG(Physical functioning) the resident was coded as requiring set-up help with eating, oral hygiene. Dependent on staff for oral hygiene and toileting hygiene. The care plan read that Resident #172 was at risk for nutritional problems related recent hospitalization , revised on 5/31/22. The goal for the resident was that the resident would avoid significant weight change through next review. An intervention for Resident #172 was labs as ordered. A review of the facility data report indicated Resident #172 was discharged and transferred to a short-term general hospital for inpatient care on 6/2/22 at 4:00 PM. A review of a Nurse Practitioner (NP) note dated on 6/02/22 at 12:18 PM., read that Resident #172 had an abnormal Creatinine Level. The note indicated, We have discussed these lab results and what it might mean and why it needs to be worked up in an in-patient setting. He needs to be sent to the hospital for deeper work up given the increase. On 5/07/24 at approximately 10:30 AM., a phone interview was conducted with Family Member (FM) #2 concerning the above issue. FM #2 said that the facility staff did not notify her of a change in condition concerning abnormal labs nor was she informed of Resident #172's transfer to the local hospital until a relative called the facility and was informed that resident was sent to the hospital. On 5/10/24 an interview was conducted at 11:09 AM., with Administrative Staff (D) concerning Resident #172. Administrative Staff (D) said that normally a transfer and a change of condition form would be completed, but no form is available in the resident's chart. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/24 at 9:51 AM., an interview was conducted with Licensed Practical Nurse (LPN) (L), concerning hospitalization s. LPN (L) said that normally if a resident is being admitted to the hospital a Change of Condition form is completed, the responsible party and physician should be notified. On 5/14/24 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Regional Nurse Consultant. The Regional Nurse Consultant said that STAT (now) labs could have been done at the facility and the family member should have been called about the labs and hospital transfer.

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F 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40711

Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the resident's care plan to include their goals after being transferred to the hospital for 1 of 50 residents (Resident #172), a closed record sample in the survey sample.

The findings included:

Resident #172 was originally admitted to the facility 05/27/2022 and discharged on [DATE]. The current diagnoses included acute kidney failure.

The entry Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 06/02/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #172 cognitive abilities for daily decision making were moderately impaired.

The Discharge Minimum Data Set (MDS) assessment with an assessment reference date of 6/02/22 coded resident as being discharged with return anticipated.

In sectionGG(Physical functioning) the resident was coded as requiring set-up help with eating, oral hygiene. Dependent with oral hygiene and toileting hygiene.

The care plan read that Resident #172 was at risk for nutritional problems related recent hospitalization , revised on 5/31/22. The goal for the resident was to avoid significant weight change through next review. An intervention for Resident #172 was labs as ordered.

A review of the facility data report indicated Resident #172 was discharged and transferred to a short-term general hospital for inpatient care on 6/2/22 at 4:00 PM. The document was created on 6/03/22 at 9:47 AM., to local hospital.

A review of a Nurse Practitioner (NP) note dated on 6/02/22 at 12:18 PM., read that Resident #172 had an abnormal Creatinine Level. The note indicated, We have discussed these lab results and what it might mean and why it needs to be worked up in an in-patient setting. He needs to be sent to the hospital for deeper work up given the increase.

On 5/10/24 an interview was conducted at 11:09 AM., with Administrative Staff (D) concerning Resident #172. Administrative Staff (D) said that normally a transfer and a change of condition form would be completed, but no form is available in the resident's chart.

On 05/14/24 at 9:51 AM., and interview was conducted with Licensed Practical Nurse (LPN) (L), concerning hospitalization s. LPN (L) said that normally if a resident is being admitted to the hospital, a medication list is sent, a bed hold policy, if resident has a Do Not Resuscitate (DNR) order (a copy is sent), Change of Condition (CIC) form, a transfer form and care plan.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at approximately 3:30 p.m., the above findings were reviewed with the Administrator, Director of Nursing and Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49917 Based on staff interview, clinical record review, and review of facility documents, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of a discharge and admission to a local hospital for 3 of 50 residents (Residents #101, #172, and #176) in the survey sample. The findings included: 1. Resident #101 was originally admitted to the facility 11/7/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included metabolic encephalopathy, muscle weakness, cognitive communication deficit, and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/25/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #101's cognitive abilities for daily decision making were moderately impaired. A review of Resident #101's nurses note dated 1/20/24 at 10:28 AM read patient was sent to emergency room at the local hospital due to altered mental status. The nurses note further read that the patient representative was notified of this transfer. An interview was conducted with the Director of Social Work on 5/13/24 at 3:05 PM. The Director of Social Work stated that she does not have evidence that notification was sent to the Ombudsman of the reason for transfer/discharge to hospital for Resident #101 on 1/20/24. The Director of Social Work further stated that during the month of January 2024 she thought that another individual was sending the notification's however compliance was not achieved. On 5/14/24 at approximately 3:45 PM, a final interview was conducted with the Administrator, Assistant Administrator, Regional Nurse Consultant, and Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. 40711 2. For Resident #172, a closed record resident, the facility staff failed to send a notice to a representative of the Ombudsman office for Resident #172's discharge to the hospital. Resident #172 was originally admitted to the facility 05/27/2022 and discharged on [DATE]. The current diagnoses included acute kidney failure. A review of the clinical records indicated this resident was admitted to the hospital on 06/02/22. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The entry Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 06/02/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #172 cognitive abilities for daily decision making were moderately impaired. The Discharge Minimum Data Set (MDS) assessment with an assessment reference date of 6/02/22 coded resident as being discharged with return anticipated. In sectionGG(Physical functioning) the resident was coded as requiring set-up help with eating, oral hygiene. Dependent with oral hygiene and toileting hygiene. The care plan read that resident #172 was at risk for nutritional problems related recent hospitalization (revised on 5/31/22). The goal for the resident to avoid significant weight change through next review. An intervention for Resident #172 was labs as ordered. On 5/14/24 at approximately 9:57 AM., the Social Worker (SW) presented a binder with Ombudsman notifications. The Ombudsman notifications were reviewed from June 2022 through August 2022. No Ombudsman notifications were uncovered for Resident #172. A review of a Nurse Practitioner note dated on 6/02/22 at 12:18 PM., read that Resident #172 had an abnormal Creatinine Level. We have discussed these lab results and what it might mean and why it needs to be worked up in an in-patient setting. He needs to be sent to the hospital for deeper work up given the increase. On 5/10/24 an interview was conducted at 11:09 AM., with Administrative Staff (D) concerning Resident #172. Administrative Staff (D) said that normally a transfer and a change of condition form would be completed, but no form is available in the resident's chart. On 05/14/24 at 9:51 AM., with Licensed Practical Nurse (LPN) (L), concerning hospitalization s. LPN (L) said that normally if a resident is being admitted to the hospital, a medication list is sent, a bed hold policy, if resident has a Do Not Resuscitate (DNR) order (a copy is sent), Change of Condition (CIC) form, a transfer form and care plan including notice to the local Ombudsman. On 5/14/24 at approximately 3:30 p.m., the above findings were reviewed with the Administrator, Director of Nursing and Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 34894 3. For Resident # 176, the facility staff failed to notify the Ombudsman when transferred to hospital on 01/02/23. Resident # 176 was admitted to the facility in October 2021 with diagnoses that included but were not limited to: unspecified dementia, fracture of the left knee, prosthetic knee joint, diastolic congestive heart failure, repeated falls, chronic obstructive pulmonary disease, dysphagia, diabetes mellitus, cerebral infarction and asthma. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent MDS (minimum data set) assessment was a Quarterly assessment with an ARD (Assessment Review Date) of 10/18/22. The MDS coded Resident # 176 with severe cognitive impairment. Resident # 176 required extensive assistance of one to two staff persons with ADLs (activities of daily living). Functional status for activities of daily living were coded as requiring extensive to total assistance of one to two staff persons. The MDS coded Resident # 176 as frequently incontinent of bowel and always incontinent of bladder. Review of the closed clinical record was conducted 5/7/24-5/14/24. Review of the Progress Notes revealed documentation that Resident # 176 was transferred to the hospital on 1/2/2023 due to altered mental status. The note stated that the transfer was at the family's request. On 05/10/2024 at 9:50 a.m., a copy of the ombudsman notification was requested. The Administrator stated he would check with the Social Worker. A copy of the facility policy regarding resident transfers was requested and received. On 05/10/2024 at approximately 12:00 p.m., an interview was conducted with the Social Services Director. She stated the notices were sent to the Ombudsman monthly. Review of the Ombudsman notifications revealed no notice of Resident # 176 being transferred from the facility. On 05/14/24 during the end of day debriefing,, the Administrator and DON (Director of Nursing) were notified of findings of the Ombudsman not being notified. No further information was provided.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 34894 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide a written copy of the bed hold policy to the responsible party when two Residents were transferred to the hospital (Resident #176, and #172) in a survey sample of 50 Residents. The findings included: 1. For Resident # 176, the facility staff failed to provide a written copy of the bed hold policy to the responsible party when transferred to hospital on 01/02/2023. Resident # 176 was admitted to the facility in October 2021 with diagnoses that included but were not limited to: unspecified dementia, fracture of the left knee, prosthetic knee joint, diastolic congestive heart failure, repeated falls, chronic obstructive pulmonary disease, dysphagia, diabetes mellitus, cerebral infarction and asthma. The most recent MDS (minimum data set) assessment was a Quarterly assessment with an ARD (Assessment Review Date) of 10/18/2022. The MDS coded Resident # 176 with severe cognitive impairment. Resident # 176 required extensive assistance of one to two staff persons with ADLs (activities of daily living). Functional status for activities of daily living were coded as requiring extensive to total assistance of one to two staff persons. The MDS coded Resident # 176 as frequently incontinent of bowel and always incontinent of bladder. Review of the closed clinical record was conducted 5/7/2024-5/14/2024. Review of the Progress Notes revealed documentation that Resident # 176 was transferred to the hospital on 1/2/2023 due to altered mental status. The note stated that the transfer was at the family's request. The physician wrote the following excerpt under the assessment and plan: ASSESSMENT/PLAN: -Lethargy - she is not at her regular baseline nothing by report to explain this. BP and BS stable. Oxygen levels 90% but weaker pulses. Will send to the ER for further evaluation - family prefers this over attempted in house work up .Full report given to EMS (Emergency Medical Service). On 05/10/2024 at 9:50 a.m., a copy of the written bed hold policy notification was requested. The Administrator stated he would check with the Social Worker. A copy of the facility policy regarding resident transfers was requested and received. On 05/10/2024 at 10:00 a.m., a copy of the bed hold policy was requested from the the Social Worker who stated Nursing does the bed holds. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaufont Health and Rehabilitation Center	200 Hioaks Road Richmond, VA 23225

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/10/2024 at 10:30 a.m., an interview was conducted with Licensed Practical Nurse D who stated there was no noted documentation of a bed hold policy being given to Resident # 176's Responsible Party. A copy of facility policy regarding resident transfers was requested. Review of the SNF/NF (Skilled Nursing Facility/Nursing Facility) Hospital Transfer Form dated 1/2/2023 revealed Resident # 176 was transferred to the hospital 1/2/2023 at 9:40 a.m. for Altered Mental Status. The most recent pain level was a 5 out of 10 at 1/2/2023 at 05:57. The code status for Resident # 176 was DNR (Do Not Resuscitate). Usual mental status was listed as alert, disoriented, but cannot follow simple instructions. Under wounds was listed: bruising and hematomas to the face s/p (status post) fall and wound to buttock. A copy of the resident Acute Transfer Document checklist form was reviewed. The form listed Copies of Documents to be sent with Resident/Patient (check all that apply). Nothing was checked on the form. Documents Recommended to Accompany Resident/Patient: Resident- seven items were listed from which to choose. Under the section entitled Send these Documents if available, there were 7 items listed from which to choose. Under the section entitled Emergency Department, there was a statement that read Please ensure that these documents are forwarded to the hospital unit if this resident/patient is admitted . EMT Signature (optional) Transport Team Signature (optional) The form was not signed nor completed by facility staff members. It only had Resident # 176's name typed on the form. On 05/14/2024 at approximately during the end of day debriefing, the Administrator and DON (Director of Nursing) were notified of findings. There was no documentation of the responsible party receiving a written bed hold policy when Resident # 176 was transferred to the hospital. No further information was provided. 40711 2. For Resident #172, the facility staff failed to provide Resident #172 or resident's representative a copy of the bed hold policy when discharged and admitted to the hospital on 6/02/22. Resident #172 was originally admitted to the nursing facility on 5/27/22. The current diagnoses included; Acute Kidney Failure. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The entry Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 06/02/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #172 cognitive abilities for daily decision making were moderately impaired. In sectionGG(Physical functioning) the resident was coded as requiring set-up help with eating, oral hygiene. Dependent with oral hygiene and toileting hygiene. The care plan read that resident #172 was at risk for nutritional problems related recent hospitalization (revised on 5/31/22). The goal for the resident was to avoid significant weight change through next review. An intervention for Resident #172 was labs as ordered. The Discharge Minimum Data Set (MDS) assessment with an assessment reference date of 6/02/2022 coded resident as being discharged with return anticipated. A review of the medical record revealed no bed hold was offered. A review of a Nurse Practitioner note dated on 6/02/22 at 12:18 PM., read that Resident #172 had an abnormal Creatinine Level. We have discussed these lab results and what it might mean and why it needs to be worked up in an in-patient setting. He needs to be sent to the hospital for deeper work up given the increase. According to the Resident Representative she was not notified by the facility staff that Resident #172 was being transferred to the hospital. On 5/14/24 at 9:51 AM., with Licensed Practical Nurse (LPN) (L), concerning hospitalization s. LPN (L) said that normally if a resident is being admitted to the hospital, a bed hold should be offered to the resident or resident representative. On 5/14/24 at approximately 3:30 p.m., the above findings were reviewed with the Administrator, Director of Nursing and Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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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** 31199 Based on Resident interview, staff interview, facility record review, and clinical record review, the facility staff failed to develop and implement a comprehensive care plan for two Residents (Resident #40, and #179) in a survey sample of 50 Residents. The findings included: 1. For Resident #40, the facility staff failed to care plan oxygen saturation and titration of oxygen administration to meet the needs of the Resident. Resident #40 was originally admitted to the facility on [DATE]. The Resident went out to the hospital on 3-19-24 with acute hypoxia, and returned on 4-10-24 to the facility with diagnoses including; Acute and chronic respiratory failure with hypoxia, muscle weakness, chronic obstructive pulmonary disease (COPD), acute pulmonary edema, morbid obesity, asthma, iron deficiency anemia, diabetes, and shortness of breath. Resident #40's most recent Minimum Data Set (MDS) assessment was a discharge assessment with an Assessment Reference Date (ARD) of 4-29-24. Resident #40 was Alert and oriented to person, place, time and situation indicating no cognitive impairment according to staff documentation, and interview by the surveyor. Resident #40 required extensive assistance from staff members for activities of daily living. On 5-6-24 at 2:15 PM, Resident #40 was interviewed via telephone. The Resident stated that her oxygen concentrator while she was a Resident in the facility could provide only 5 liters of oxygen, and that was insufficient for her needs. She further stated that the staff did not check her oxygen saturation (SPo2) levels regularly, that it was hit and miss which meant they could not see, and didn't know when I needed more oxygen. She went on to state that the nurses don't know what they are doing, the doctor wants me to be on 10 liters when I get short of breath, but they don't do it, and the Administrator said I was using too many portable tanks. Review of physician's orders revealed that the following oxygen orders were documented; Ordered 2-13-24, discontinued 2-13-24, O2 at 4 liters per minute via nasal cannula continuous. Ordered 2-13-24, discontinued 3-23-24, O2 at 5 liters per minute via nasal cannula continuous. Ordered 4-10-24, discontinued 4-30-24, O2 at 6 liters per minute via nasal cannula, may titrate as needed to maintain O2 SATs (SPO2) above 90% continuous. Review of the Vital signs record, and physician/nursing progress notes revealed the following; On 3-15-24 the physician evaluated the Resident for increased oxygen demands, patient up to 10 liters via nasal cannula, and a chest x-ray was ordered by the physician. The doctor also ordered Bumetanide 4 milligrams twice per day medication for 5 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3-16-24 the Registered Nurse Practitioner evaluated the Resident documenting a follow up visit due to shortness of breath, and ordered continuous O2 (oxygen) via nasal cannula titrate up to 10 liters with humidity to maintain SATs (SPO2) greater than 93%. Continue Bumetanide for 7 days 4 milligrams twice per day. It is important to mention that a normal SPO2 is 95-100%. (10 liters per minute was never appeared in the physician orders as a limit for titration.) On 3-18-24 a nursing progress note documented that staff spoke with a tech from (business name with unknown initials) who was assigned to obtain the chest x-ray. This is the only note from 3-16-24 to 3-19-24 when the Resident was sent out to the hospital. On 3-19-24 at 6:00 AM no chest x-ray had been completed, and the Resident's SPO2 was at 66%. At 8:56 AM the physician was notified and ordered the Resident to be sent to the emergency room immediately. On 4-10-24 the Resident returned to the facility with an SPO2 of 93%, on 6 liters of oxygen via nasal cannula. Physician progress notes revealed that humidified oxygen should be continued and titrated to 10 liters per minute to maintain SPO2 at 88-92% as needed and for intermittent acute hypoxia, and bumetanide decreased to 1 milligram twice per day. On 4-11-24 at 2:22 AM the nurse documented Resident oxygen levels at 80%, complaints of shortness of breath due to a malfunctioning concentrator per Resident. O2 at 6 liters via nasal cannula, unlabored breathing, not in distress and comfortable. Wants oxygen to be increased to 10 liters per minute. Educated on the 6 liters ordered by the doctor .Resident not receptive to caregivers suggestions to promote her health Resident turned oxygen to 10 liters. On 4-11-24 at 4:58 AM O2 at 6 liters, not in distress according to nursing notes. On 4-11-24 at 11:59 PM the doctor visited the Resident and saw her sitting in a wheelchair with oxygen infusing at 8 liters per minute from an oxygen tank. The doctor documented that the Resident complained that her 5 liter concentrator was not working well. On 4-14-24 at 11:59 PM the Nurse practitioner again documents that the Resident feels that the oxygen concentrator is defective. On 4-15-24 at 8:38 PM the Resident complained to nursing that she was short of breath, nursing documented SPO2 at 79% on the concentrator, and then went up to 87% when placed on the portable oxygen tank. On 4-21-24 at 3:22 PM a nursing note documented Patient alert and oriented continues to wear O2 at 10 on her concentrator against medical advice. On 4-22-24 at 8:48 PM nursing notes documented In chair on 6 liters of oxygen via nasal cannula with no complaints . On 4-29-24 the Resident complained of shortness of breath and was sent to the hospital via ambulance and did not return. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan (dated 2-15-24) revealed: The resident is at risk for respiratory complications, secondary to COPD, supplementary oxygen requirement. As interventions, the nurses were directed to provide: Administer nebulizer treatments as ordered, administer oxygen as ordered, Bipap/Cpap as ordered, assess oxygen saturation as needed, provide education on oxygen therapy. None of the care plan interventions were measurable and none of the SPO2 daily monitoring or titration of oxygen to meet the physician ordered oxygenation percentage was ever included in the care plan for nursing to follow. Those assessments were sporadic and from the 4-10-24 readmission until final discharge on 4-29-24, they only occurred on 9 of 20 days. The chest x-ray was never completed, and no record of it was in the clinical record. It was discontinued on 5-18-24 as completed, however, there was no record found in the clinical record by nursing staff nor by surveyors. No order was documented for Oxygen saturation assessments daily to monitor for hypoxia in order to titrate the oxygen to 10 liters per minute as was ordered in the physician progress notes on 3-16-24, and again on 4-10-24 to maintain the Resident's oxygenation between 88% and 92%. The Resident continued to complain that the oxygen concentrator was not working properly, and nursing staff counseled the Resident not to increase oxygen to 10 liters on 4-11-24, and 4-21-24 which the doctor had prescribed, with staff seemingly unaware of the order. On 5-9-24 at approximately at 10:00 AM, LPN (licensed practical nurse) anonymous was interviewed about the resident. The nurse was afraid of retaliation and stated she did not want to be identified. She stated, I told them the patient was not getting enough oxygen, and we should keep her on the tanks, but I was told by administration that she was using too many tanks and she had to be on the concentrator. I didn't know she was supposed to have her SATs checked like that and her oxygen increased, or I would have done it anyway. The facility Oxygen use policy was reviewed and revealed: Licensed staff will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per provider's orders and in accordance with standards of practice. Monitor and record saturation levels and vital signs as indicated, or by provider's order. Document oxygen delivery flow rate, method of delivery, date and time, saturation levels if indicated, in the electronic medical record. Document oxygen saturation level/and or vital signs in the electronic medical record as indicated, and any unusual findings and follow-up interventions including provider and responsible party notification. On 5-9-24, at 12:00 PM, and on 5-10-24 at 12:00 PM, the Administrator and Corporate RN were made aware of the lack of respiratory assessments and oxygen administration for Resident #40. They stated they had nothing further to provide. 2. For Resident #179, the facility staff failed to complete a care plan for Intravenous (IV) antibiotics after an infection from a status post knee replacement with acute hospitalization follow up for the post operative infection. Resident #179, was admitted to the facility on [DATE] at 6:30 PM, and discharged on [DATE] after 8:00 AM. Diagnoses included; After care following joint replacement surgery, infection due to right knee internal prosthetic, hypertension, hyperthyroidism, obesity, and gastroesophageal reflux disease (GERD). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #179's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-29-24 was coded as a discharge assessment. Resident #179 was coded as having no cognitive impairment. Resident #179 was also coded as requiring supervision or limited dependence on one staff member to perform activities of daily living, such as hygiene, transferring, and bed mobility. The Resident's physician orders were reviewed and revealed an order for antibiotics. The order was for the following; 1-16-24 Penicillin G Potassium 20,000,000 units use 4 milliunit IV every 4 hours, start 1-16-24. The Medication and Treatment Administration Record (MAR/TAR) was reviewed for January 2024, and revealed the absence of nursing signatures on some occasions, and a signature with the number 9 added to it indicating the antibiotic was not administered on 9 of 79 occasions. Those follow; 1-16-24 - 8:00 AM, 12:00 PM, 4:00 PM 1-17-24 - 4:00 AM 1-18-24 - 4:00 PM 1-24-24 - 12:00 PM 1-27-24 - 8:00 AM, 12:00 PM, 4:00 PM Nursing medication administration notes do not indicate why the antibiotics were not administered as ordered, and why they were omitted. Only one nursing orders administration note existed in the clinical record completed by LPN J which documented medication not available, MD (doctor), RP (responsible party), nursing managers are aware medication has been stat ordered, on 1-16-24 at 6:53 PM. Guidance for the administration of Insulin is given by The National Institutes of Health (NIH), and is as follows; National Institutes of Health & Medline.gov; Antibiotics must be given as per a doctor's order and on the schedule indicated. If a dose is missed the doctor must be notified. Do not miss doses. Do not discontinue this medication without seeking a doctor's help. Stopping Antibiotics increases the likelihood of MDRO's (multi drug resistant organisms) such as Methycillin Resistant Staphyloccocus Aureus (MRSA), and can result in rebound infections which can be life threatening. Resident #179's care plan was reviewed and revealed no care plan for IV antibiotic infusions for an active infection. Nursing and physician progress notes were reviewed, and revealed no notes documenting that the medication had been unavailable omitted, nor that the doctor was made aware of the omissions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews conducted on 5-8-24, and 5-9-24 with nursing staff on both units revealed that the expectation for all medications is that they are available and administered per physician's order. They were in agreement that if there was a hole (no signature), or a 9 on the medication administration record (MAR), that the medication was not administered. On 5-10-24 at 11:00 a.m., the DON (director of nursing) and Administrator were interviewed in the conference room and stated that they had been unaware that medications had not been given, nor that the doctor and family were not notified of medications being omitted by staff. The DON was a new staff member and had recently been hired. On 5-13-24 at approximately 4:30 p.m., at the end of day debrief, the Administrator and DON were again made aware of the failure of staff to prevent significant medication errors in unavailable and omitted Antibiotics as ordered. No further information was provided.

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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** 34894 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to maintain the professional standards of medication administration in nursing practice for two Residents (Resident # 6 and #37) in a survey sample of 50 Residents. The findings included: For Resident # 6, the facility staff failed to administer medications and treatments on several dates as ordered by the physician Resident # 6 was admitted to the facility in April 2024 with diagnoses that included but were not limited to: Dementia, contractures and sepsis. Resident #6's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 04/12/2024 was a quarterly assessment. The MDS coded Resident # 6 with a BIMS (Brief Interview for Mental Status) score of 10 out of 15, indicating moderate cognitive impairment. The MDS coded Resident # 6 as requiring extensive to total staff assistance with Activities of Daily Living. Resident # 6 was coded as incontinent of bowel and bladder. Review of the clinical record was conducted 5/7/2024-5/14/2024. The Medication and Treatment Administration Record (MAR/TAR) was reviewed for March 2024 and April 2024, and revealed the absence of nursing signatures indicating the treatments were not completed on 9 occasions. Those dates were as follows: Med Plus 2.0 two times a day for Supplement -Order Date-10/17/2023 scheduled at 9:00 a.m. and 6:00 p.m. Not administered on 3/12/2024 at 6 p.m., 3/13/2024 at 6 p.m. and 3/18/2024 at 6 p.m. Tramadol HCl Oral Tablet 50 MG (milligrams) Give 1 tablet by mouth every 6 hours for pain -Order Date-12/06/2023 0829 scheduled 12 midnight, 6:00 a.m., 12 noon and 6:00 p.m. Not administered on 3/12/2024 at 6 p.m., 3/13/2024 at 6 p.m. and 3/18/2024 at 6 p.m. Santyl External Ointment 250 UNIT/GM (gram) (Collagenase) Apply to Left Buttock topically every night shift for Unstageable -Order Date-01/29/2024 0910. Not administerd on 3/5/2024 on night shift. WOUND CARE- Right ischium: Cleanse with soap & water, pat dry then apply collagen particles & xeroform, cover with bordered foam every day shift for Abrasion -Order Date- (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/07/2024 1257. Not administered 3/17/2024, 3/22/2024, 3/24/2024, 3/28/2024, and 3/29/2024 WOUND CARE - Right buttocks: Cleanse with soap and water, apply zinc leave ota (open to air) three times a day for incontinence TID and PRN (as needed) -Order Date- 02/05/2024 0941. Not administered 3/2/2024 at 9 p.m., 3/6/2024 at 9 p.m., and 3/6 /2024 at 2 p.m. Nursing medication administration notes did not indicate why the treatments were not completed, and why medications were omitted. Nurses on the nursing unit were asked about blanks in documentation and the responses were if it's not documented, it's not done. There were valid Physician orders for the medications and treatments that were omitted. The nursing facility stated Mosby's as their nursing standard. Mosby's stated all medications must be administered by the physician's order. Guidance for nursing standards for the administration of medication provided by Fundamentals of Nursing, 7th Edition, Mosby's/ [NAME]-[NAME], p. 705 stated Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation. Resident 6's care plan was reviewed and revealed a care plan that instructed to administer medications and treatments as ordered by the physician. Nursing and physician progress notes were reviewed, and revealed no notes documenting that the medications had been omitted, nor that the doctor was made aware of the omissions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/10/2024 at 10:20 a.m., an interview was conducted with Licensed Practical Nurse D who stated the expectation was for nurses to administer medications and treatments as ordered by the physician. She stated that nurses should document immediately after administration of medications and treatments. Also, LPN-D stated that if the space was empty it would appear that it was not done. On 5/14/2024, during the end of day debriefing with all surveyors, the Administrator and Director of Nursing were made aware of the failure of staff to administer medications as ordered. The Director of Nursing stated the expectation was for the staff to administer medications and treatments as ordered by the physician. No further information was provided. 2. For Resident #37, the facility staff failed to administer the proper dose of Lovenox as ordered by the physician on 05/06/2024. Resident #37 was originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of, but not limited to, urinary tract infection (UTI), bacteremia, extended spectrum beta lactamase (ESBL), history of deep vein thrombosis (DVT), diabetes, malignant neoplasm of the prostate, chronic kidney disease and abnormal gait. The most recent MDS (minimum data set) was a quarterly assessment with an (ARD) assessment reference date of 04/06/2024 was reviewed and revealed a (BIMS) Brief Interview for Mental Status score of 15 out of 15 which indicated no cognitive impairment . On 05/07/2024, a medication administration observation with LPN (Licensed Practical Nurse) #B, revealed that Resident #37's dosage for Lovenox was changed by the physician on 05/05/2024 from 40 mg (milligrams) to 90 mg subcutaneously to start on 05/06/2024. The box of Lovenox injections observed on hand for Resident #37 on the medication cart was 40 mg/ml (milligrams per milliliter). The medication administration record (MAR) documented that the Lovenox 100mg/ml 0.9 ml was administered to Resident #37 on 05/06/2024 at 9 a.m. and 5 p.m ., but only Lovenox 40mg/ml was on the medication cart for Resident #37. The Unit Manager was notified of the dosage change and that the new dosage of Lovenox for Resident #37 was not on the med cart. The Unit Manager, returned with an unopened supply of Lovenox 100mg/ml that had been delivered and stored in the wrong medication cart overnight on 05/05/24 but, not identified or administered. An interview was conducted on 05/07/2024 with Resident #37 who stated that he received his Lovenox injection twice on 05/06/2024. Resident stated he was aware that his Lovenox dosages changes. An interview was conducted with LPN #D on 05/07/2024 at approximately 2:00 p.m. who stated she was informed of the medication error, that Resident #37 received Lovenox 40mg/ml twice on 05/06/204 instead of the new dosage of 100 mg/ml .9ml dosage by LPN #B. LPN #D stated that she had informed and assessed Resident #37 for adverse effects and had notified the physician (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 05/07/2024 progress note revealed: Spoke with resident today in regards his Lovenox injection. Resident was receiving 40ml Lovenox injections BID. The order was changed to Lovenox injection 100ml BID to start on 05/06/2024. Instead of receiving the 100 ml resident received the old dosage of the 40ml at 9 a.m. and 5 p.m. Resident has shown no adverse effects of the administration of this medication. Resident is alert and oriented and ho changes from baseline. Residents is his own RP and MD had been made aware of the error as well. Med error plan of correction in place. Will continue to monitor resident. [SIC] On 05/06/2024, Resident #37's clinical record was reviewed and revealed physician orders and medication administration documentation as follows: -Lovenox injection solution prefilled syringe 40 MG/ML (Enoxaparin Sodium) inject 0.4ml two times a day for History of DVT discharge (d/c) date 05/05/2024 -Lovenox injection solution prefilled syringe 100 MG/ML (Enoxaparin Sodium) inject 0.9 ml subcutaneously two times a day for History of DVT Order date 05/05/2024 1009 During the end of day debriefing on 05/08/2024, the Administrator and Regional Nurse Consultant were informed of findings during med pass 05/07/2024. On 05/08/2024 the Pharmacy Delivery Manifest was requested and revealed Enoxaparin /Lovenox 100 mg/ml syringes 10 was delivered to the east wing on 05/05/2024 at 11:03 p.m. During the end of day debriefing on 05/13/2024, the Administrator, Regional Nurse Consultant and Director of nursing were informed of the findings. No further information was provided.

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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. 34894 Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a discharge summary for 1 Resident (Resident # 176) in the survey sample of 50 residents. Findings included: For Resident # 176, the facility staff failed to complete a discharge summary after the a transfer to the hospital on 01/02/2023. Resident # 176 was admitted to the facility in October 2021 with diagnoses that included but were not limited to: unspecified dementia, fracture of the left knee, prosthetic knee joint, diastolic congestive heart failure, repeated falls, chronic obstructive pulmonary disease, dysphagia, diabetes mellitus, cerebral infarction and asthma. The most recent MDS (minimum data set) assessment was a Quarterly assessment with an ARD (Assessment Review Date) of 10/18/2022. The MDS coded Resident # 176 with severe cognitive impairment. Resident # 176 required extensive assistance of one to two staff persons with ADLs (activities of daily living). Functional status for activities of daily living were coded as requiring extensive to total assistance of one to two staff persons. The MDS coded Resident # 176 as frequently incontinent of bowel and always incontinent of bladder. Review of the closed clinical record was conducted 5/7/2024-5/14/2024. Review of the progress notes revealed documentation that Resident # 176 was transferred to the hospital on 01/02/2023. Further review of the progress notes and other sections of the clinical record revealed no documentation of a Discharge Summary. Resident # 176 did not return to the facility. During the end of day debriefing on 5/10/2024, the Administrator and Regional Nurse Consultant were informed of the findings. A copy of the Discharge Summary and the facility's policy was requested. Review of the Facility's policy entitled Discharge Summary revealed the statement A Discharge Summary must be completed by the physician for every discharge unless the Center is using the continuous chart procedure and the patient has been readmitted within thirty days. During the end of the day debriefing on 5/13/2024, the Administrator, Regional Nurse Consultant and Director of Nursing were informed of the findings of no discharge summary for Resident # 176. A copy of the Discharge Summary was not presented to the surveyor prior to survey exit. No further information was provided.

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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. 34894 Based on staff interview, and clinical record review, the facility failed to provide care and services necessary to maintain good grooming for one resident (Resident # 6) in a survey sample of 50 residents. Findings included: For Resident # 6, the facility staff failed to provide grooming/nail care resulting in fingernails over 1/2 inch long on contracted hands. Resident # 6 was admitted to the facility in April 2024 with diagnoses that included but were not limited to: Dementia, contractures and sepsis. Resident #6's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 04/12/2024 was a quarterly assessment. The MDS coded Resident # 6 with a BIMS (Brief Interview for Mental Status) score of 10 out of 15, indicating moderate cognitive impairment. The MDS coded Resident # 6 as requiring extensive to total staff assistance with Activities of Daily Living. Resident # 6 was coded as incontinent of bowel and bladder. Review of the clinical record was conducted 5/7/2024-5/14/2024. Review of the ADL documentation report for April 2024 and May 2024 revealed no documentation of nail care for Resident # 6. On 5/7/2024 at 10:30 a.m., Resident # 6 was observed lying in bed with contractures of both hands. The fingernails on both hands were very long at over a half an inch over the tip of the fingers. On 5/7/2024 at 1:15 p.m., Resident # 6 was observed sitting in a Geri-Chair at the nurses station. The fingernails were observed to be long and almost touching the palm of the hands. On 5/7/2024 at 2:44 p.m., an interview was conducted with CNA (Certified Nursing Assistant)-C who stated the residents should receive assistance as needed for activities of daily living. CNA-C stated staff should document the care provided. On 5/8/2024 at 2:33 p.m., an interview was conducted with CNA-B who stated the facility expected ADL care to be provided for residents and documentation should be done every shift. CNA-B stated sometimes Resident # 6 refused to allow the staff to provide care. When asked what the CNA should do if a resident refused care, CNA-B stated the nurse should be informed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/2024 at 2:49 p.m., an interview was conducted with the Wound Care Nurse who stated the facility staff was expected to provide ADL care including incontinence care and nail care. The Wound care nurse stated whenever any resident refused any care, that should be documented, and the nurse should be notified. She stated that blanks in the documentation would indicate that it was not done. The Wound Care nurse stated that she was new in her position but that she administered treatments daily as ordered by the physician when she was on duty. She stated that she made rounds with the wound care nurse practitioner once a week and documented the assessments. She stated the nurses were expected to administer treatments as ordered by the physician. Nurses were expected to notify her of any new wounds discovered during the assessments or during skin checks by the CNAs. The Wound Care nurse stated that long fingernails on a contracted hand was a risk for development of a pressure wound in the palm of the hand. She stated the fingernails should be kept short and devices placed in the contracted hands to prevent the development of pressure wound. She stated she would check to see if Resident # 6 had a referral to Occupational therapy to address the contractures. On 5/8/2024 at 4:45 p.m., an interview was conducted with LPN (Licensed Practical Nurse)-B who stated the expectation was for staff members to provide care to the residents and to document the assistance provided. LPN-B stated that if residents refused to allow staff to provide care, the staff were expected to immediately report the refusal to the nurse. On 5/13/2024 during the end of day meeting, the Administrator, Director of Nursing and Corporate Nurse Consultant were informed of the findings. No further information was provided.

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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** 34894 Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to provide treatment and services for pressure wounds for two Residents (Residents # 6 & # 87) in a survey sample of 50 Residents. 2. For Resident #87, the facility staff failed to administer wound care according to physician orders. The Findings Included: 1. For Resident #6, the facility staff failed to provide nail care to reduce the risk of development of new pressure wounds in the palms of the hands and failed to consistently provide treatments for pressure wound care per physician orders. Resident # 6 was admitted to the facility in April 2024 with diagnoses that included but were not limited to: Dementia, contractures and sepsis. Resident #6's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 04/12/2024 was a quarterly assessment. The MDS coded Resident # 6 with a BIMS (Brief Interview for Mental Status) score of 10 out of 15, indicating moderate cognitive impairment. The MDS coded Resident # 6 as requiring extensive to total staff assistance with Activities of Daily Living. Resident # 6 was coded as incontinent of bowel and bladder. Review of the clinical record was conducted 5/7/2024-5/14/2024. Review of the ADL documentation report for April 2024 and May 2024 revealed no documentation of nail care for Resident # 6. On 5/7/2024 at 10:30 a.m., Resident # 6 was observed lying in bed with contractures of both hands. The fingernails on both hands were very long at over a half an inch over the tip of the fingers. On 5/7/2024 at 1:15 p.m., Resident # 6 was observed sitting in a Geri-Chair at the nurses station. The fingernails were observed to be long and almost touching the palms of the hands. Review of Resident # 6's Progress notes and care plan revealed the resident occasionally refused care. There was no consistent documentation of attempts to encourage Resident # 6 to allow the staff to provide care to include nail care. There were interventions to treat and decrease the risk of pressure wounds. The facility policy for Documentation of Wound Treatments was reviewed and revealed the following excerpt: Wound treatments are documented at the time of each treatment . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident's care plan was reviewed and indicated the Resident would There was a care plan for wounds for Resident # 6. Physician's orders were reviewed and valid for the dates and times wound care was omitted. Staff nurse and CNA interviews were conducted during the course of the survey on all units. Those interviews indicated that the expectation for incontinence rounds was every 2 hours and as often as needed, and skin would be assessed for breakdown during that care. If skin breakdown was found by CNAs (Certified Nursing Assistants), who typically completed incontinence care, they would then immediately report it to the nurse. The nurse would then assess the area, measure it, document a description of it, and seek physician's orders to treat and prevent the wounds worsening. The nursing staff stated all skin assessments were in the computerized record, and they had no paper assessments. Interviews were conducted with the facility staff members: On 5/7/2024 at 11:15 a.m., an interview was conducted with CNA (Certified Nursing Assistant)-E who stated residents should be turned and repositioned every two hours to help prevent pressure ulcers. CNA-E stated pillows and wedges should be used to help keep pressure off of the bony areas. CNA-E stated they look at the skin when giving baths or showers and during incontinence care. CNA-E stated any areas noted should be immediately reported to the charge nurse. CNA-E stated the Rehab Department frequently gave inservices about ways to prevent or reduce the risk of pressure wounds. On 5/8/2024 at 2:24 p.m., an interview was conducted with Licensed Practical Nurse C who stated the facility had a wound care nurse who performed dressing changes daily, a wound care nurse practitioner who examined residents once a week along with the wound care nurse. On 5/8/2024 at 2:49 p.m., during observations of Resident # 6's wounds, an interview was conducted with the Wound Care Nurse who stated the facility staff was expected to provide ADL care including nail care. When asked if Resident # 6's fingernails were properly groomed or too long, she stated the fingernails were very long at over one quarter to a half inch long and that both hands were contracted. The Wound Care nurse stated that long fingernails on a contracted hand was a risk for development of a pressure wound in the palm of the hand. She stated the fingernails should be kept short and devices placed in the contracted hands to prevent the development of pressure wound. She stated she would check to see if Resident # 6 had a referral to Occupational therapy to address the contractures. The Wound care nurse stated whenever any resident refused any care, that should be documented, and the nurse should be notified. She stated that blanks in the documentation would indicate that it was not done. The Wound Care nurse stated that she was new in her position but that she administered treatments daily as ordered by the physician when she was on duty. She stated that she made rounds with the wound care nurse practitioner once a week and documented the assessments. She stated the nurses were expected to administer treatments as ordered by the physician. Nurses were expected to notify her of any new wounds discovered during the assessments or during skin checks by the CNAs. CNA-B was in the room helping to hold Resident # 6 on the side for observation of the pressure wounds on the buttocks. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/2024 at 3:01 p.m., an interview was conducted with CNA-B stated Resident # 6 often refused care. CNA-B was asked if the refusals were documented each time. CNA-B stated we are supposed to document any time they refuse and notify the nurse. On 5/8/2024 at 4:10 p.m., Resident # 6 was observed lying in bed. Fingernails had been trimmed. On 5/8/2024 at 4:35 p.m., an interview was conducted with the Unit Manager who stated Resident # 6 often refused care. The Unit Manager stated the staff should document all refusals and staff should try differing attempts to encourage the resident to allow care to be provided. She stated maybe different times or a different person would be helpful. The Unit Manager stated Resident # 6 allowed the staff to cut the fingernails after the surveyor discussed concerns with the staff members. The Unit Manager stated a referral would be made to the Rehab department to assist with reducing the risk of developing a wound in the palm of the hand. On 5/8/2024 at 4:45 p.m., an interview was conducted with the Rehab Director who stated Resident # 6 had been in the therapy case load for the contracture of the hand. The Rehab Director provided documentation of a problem of inconsistent wear of palm roll/hand hygiene issues during the period of 12/19/2023-1/17/2024. The Rehab Director stated Resident # 6 was being seen currently (at the time of survey) for knee contractures. Interventions were in place to reduce the risk of pressure wounds of the knees and ankles. On 5/9/2024 at 11:20 a.m., Resident # 6 was observed with fingernails trimmed and palm rolls in each hand. Review of the clinical record revealed physician and nursing progress notes regarding the risk for pressure wounds with plans and interventions to treat and decrease the risk of the development of new wounds. The Medication and Treatment Administration Record (MAR/TAR) was reviewed for March 2024 and April 2024, and revealed the absence of nursing signatures indicating the treatments were not completed on 9 occasions. Those dates were as follows: Santyl External Ointment 250 UNIT/GM (gram) (Collagenase) Apply to Left Buttock topically every night shift for Unstageable -Order Date-01/29/2024 0910 -D/C Date- 03/25/2024 1203 not administered on 3/5/2024 on night shift WOUND CARE- Right ischium: Cleanse with soap & water, pat dry then apply collagen particles &xeroform, cover with bordered foam. every day shift for Abrasion -Order Date- (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/07/2024 1257 -D/C Date- 03/29/2024 1528 not administered 3/17/2024, 3/22/2024, 3/24/2024, 3/28/2024, and 3/29/2024 WOUND CARE - Right buttocks: Cleanse with soap and water, apply zinc leave ota (open to air) three times a day for incontinence TID and PRN (as needed) -Order Date- 02/05/2024 0941 -D/C Date- 03/07/2024 1257 not administered 3/2/2024 at 9 p.m., 3/6/2024 at 9 p.m., and 3/6 /2024 at 2 p.m. On 5/13/2024 and 5/14/2024 during the end of day debriefing, the Administrator, and DON (Director of Nursing) were notified that the facility failed to provide care and services for pressure ulcers. Copies of inservices conducted with nursing staff were presented by the Unit Manager and Rehab Director No further information was provided by the facility. 40711 2. For Resident #87, the facility staff failed to administer wound care according to physician orders. Resident #87 was originally admitted to the facility 03/08/24 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included diabetes mellitus. The Care Plan dated 3/09/24 read that Resident #87 has chronic wound and pressure ulcers to the sacrum, left and right leg. The goal for Resident #87 the resident was that pressure ulcers/skin impairments would not develop thru the review period (3/11/24). The interventions for Resident #87 would be to keep the skin clean and dry and to assess the resident for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/12/24 coded the resident as completing a Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #87 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goal) the resident was coded as independent with eating, oral hygiene, requiring dependence with toileting hygiene, showers/bathing and personal hygiene. In Section M (Skin Conditions) the resided is coded as having 5 stage 3 pressure ulcers with all 5 being present on admission. According to the March 2024 and April 2024 Treatment Administration Record (TAR) wound care treatments were missed on the following dates: Left posterior leg, stage 3: 3/17/24, 3/22/24, 3/27/24. Right posterior leg, stage 3: 3/17/24. Sacrum stage 3: 3/17/24. Right anterior leg: 3/17/24 and 3/20/24. Current Physician Order Summary (POS) for May 2024 read: Right anterior lower leg, cleanse with wound cleanse, xeroform and cover with border gauze daily, every night shift (Order date- 05/07/2024). Right lateral ankle, cleanse with wound cleanse, xeroform and cover with border gauze daily every night shift (Order date- 05/07/2024). Sacrum wound Stage 3, cleanse with wound cleanser, Honey fiber, bordered gauze. Day shift (Start 3/12/24). A skin and wound note dated 5/6/2024 at 10:46 AM., read right lateral ankle Skin Tear/Laceration. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Xeroform to base of the wound. 3. secure with Bordered gauze 4. change Daily. On 5/08/24 at approximately 3:40 PM., a wound care observation was conducted with the wound care nurse (WCN) for Resident #87. The WCN was observed removing a bordered gauze dressing dated 5/06/24 from Resident #87's Right lateral ankle. The wound care nurse said that the night shift nurse should have changed the dressing last night (5/07/24) but they didn't. On 5/14/2024 at approximately 3:30 p.m., the above findings were reviewed with the Administrator, Director of Nursing and Corporate Nurse Consultant. The corporate nurse consultant said that wound care should have been done.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide respiratory care and services to maintain the highest practicable wellbeing for one resident, (Resident #40) in a survey sample of 50 residents, . The findings included: For Resident #40, the facility staff failed to assess and monitor the Resident's oxygen saturation and titrate oxygen administration to meet the needs of the Resident. Further, oxygen treatment orders were unclear, not followed, and not care planned for nursing staff guidance. Resident #40 was originally admitted to the facility on [DATE]. The Resident went out to the hospital on 3-19-24 with acute hypoxia, and returned on 4-10-24 to the facility with diagnoses including; Acute and chronic respiratory failure with hypoxia, muscle weakness, chronic obstructive pulmonary disease (COPD), acute pulmonary edema, morbid obesity, asthma, iron deficiency anemia, diabetes, and shortness of breath. Resident #40's most recent Minimum Data Set (MDS) assessment was a discharge assessment with an Assessment Reference Date (ARD) of 4-29-24. Resident #40 was Alert and oriented to person, place, time and situation indicating no cognitive impairment according to staff documentation, and interview by the surveyor. Resident #40 required extensive assistance from staff members for activities of daily living. On 5-6-24 at 2:15 PM, Resident #40 was interviewed via telephone. The Resident stated that her oxygen concentrator while she was a Resident in the facility could provide only 5 liters of oxygen, and that was insufficient for her needs. She further stated that the staff did not check her oxygen saturation (SPo2) levels regularly, that it was hit and miss which meant they could not see, and didn't know when I needed more oxygen. She went on to state that the nurses don't know what they are doing, the doctor wants me to be on 10 liters when I get short of breath, but they don't do it, and the Administrator said I was using too many portable tanks. Review of physician's orders revealed that the following oxygen orders were documented; Ordered 2-13-24, discontinued 2-13-24, O2 at 4 liters per minute via nasal cannula continuous. Ordered 2-13-24, discontinued 3-23-24, O2 at 5 liters per minute via nasal cannula continuous. Ordered 4-10-24, discontinued 4-30-24, O2 at 6 liters per minute via nasal cannula, may titrate as needed to maintain O2 SATs (SPO2) above 90% continuous. Review of the Vital signs record, and physician/nursing progress notes revealed the following; On 3-15-24 the physician evaluated the Resident for increased oxygen demands, patient up to 10 liters via nasal cannula, and a chest x-ray was ordered by the physician. The doctor also ordered Bumetanide 4 milligrams twice per day medication for 5 days. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Beaufont Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Hioaks Road Richmond, VA 23225	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3-16-24 the Registered Nurse Practitioner evaluated the Resident documenting a follow up visit due to shortness of breath, and ordered continuous O2 (oxygen) via nasal cannula titrate up to 10 liters with humidity to maintain SATs (SPO2) greater than 93%. Continue Bumetanide for 7 days 4 milligrams twice per day. It is important to mention that a normal SPO2 is 95-100%. (10 liters per minute was never appeared in the physician orders as a limit for titration.) On 3-18-24 a nursing progress note documented that staff spoke with a tech from (business name with unknown initials) who was assigned to obtain the chest x-ray. This is the only note from 3-16-24 to 3-19-24 when the Resident was sent out to the hospital. On 3-19-24 at 6:00 AM no chest x-ray had been completed, and the Resident's SPO2 was at 66%. At 8:56 AM the physician was notified and ordered the Resident to be sent to the emergency room immediately. On 4-10-24 the Resident returned to the facility with an SPO2 of 93%, on 6 liters of oxygen via nasal cannula. Physician progress notes revealed that humidified oxygen should be continued and titrated to 10 liters per minute to maintain SPO2 at 88-92% as needed and for intermittent acute hypoxia, and bumetanide decreased to 1 milligram twice per day. On 4-11-24 at 2:22 AM the nurse documented Resident oxygen levels at 80%, complaints of shortness of breath due to a malfunctioning concentrator per Resident. O2 at 6 liters via nasal cannula, unlabored breathing, not in distress and comfortable. Wants oxygen to be increased to 10 liters per minute. Educated on the 6 liters ordered by the doctor .Resident not receptive to caregivers suggestions to promote her health Resident turned oxygen to 10 liters. On 4-11-24 at 4:58 AM O2 at 6 liters, not in distress according to nursing notes. On 4-11-24 at 11:59 PM the doctor visited the Resident and saw her sitting in a wheelchair with oxygen infusing at 8 liters per minute from an oxygen tank. The doctor documented that the Resident complained that her 5 liter concentrator was not working well. On 4-14-24 at 11:59 PM the Nurse practitioner again documents that the Resident feels that the oxygen concentrator is defective. On 4-15-24 at 8:38 PM the Resident complained to nursing that she was short of breath, nursing documented SPO2 at 79% on the concentrator, and then went up to 87% when placed on the portable oxygen tank. On 4-21-24 at 3:22 PM a nursing note documented Patient alert and oriented continues to wear O2 at 10 on her concentrator against medical advice. On 4-22-24 at 8:48 PM nursing notes documented In chair on 6 liters of oxygen via nasal cannula with no complaints . On 4-29-24 the Resident complained of shortness of breath and was sent to the hospital via ambulance and did not return. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan (dated 2-15-24) revealed: The resident is at risk for respiratory complications, secondary to COPD, supplementary oxygen requirement. As interventions, the nurses were directed to provide: Administer nebulizer treatments as ordered, administer oxygen as ordered, Bipap/Cpap as ordered, assess oxygen saturation as needed, provide education on oxygen therapy. None of the care plan interventions were measurable and none of the SPO2 daily monitoring or titration of oxygen to meet the physician ordered oxygenation percentage was ever included in the care plan for nursing to follow. Those assessments were sporadic and from the 4-10-24 readmission until final discharge on 4-29-24, they only occurred on 9 of 20 days. The chest x-ray was never completed, and no record of it was in the clinical record. It was discontinued on 5-18-24 as completed, however, there was no record found in the clinical record by nursing staff nor by surveyors. No order was documented for Oxygen saturation assessments daily to monitor for hypoxia in order to titrate the oxygen to 10 liters per minute as was ordered in the physician progress notes on 3-16-24, and again on 4-10-24 to maintain the Resident's oxygenation between 88% and 92%. The Resident continued to complain that the oxygen concentrator was not working properly, and nursing staff counseled the Resident not to increase oxygen to 10 liters on 4-11-24, and 4-21-24 which the doctor had prescribed, with staff seemingly unaware of the order. On 5-9-24 at approximately at 10:00 AM, LPN (licensed practical nurse) anonymous was interviewed about the resident. The nurse was afraid of retaliation and stated she did not want to be identified. She stated, I told them the patient was not getting enough oxygen, and we should keep her on the tanks, but I was told by administration that she was using too many tanks and she had to be on the concentrator. I didn't know she was supposed to have her SATs checked like that and her oxygen increased, or I would have done it anyway. The facility Oxygen use policy was reviewed and revealed: Licensed staff will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per provider's orders and in accordance with standards of practice. Monitor and record saturation levels and vital signs as indicated, or by provider's order. Document oxygen delivery flow rate, method of delivery, date and time, saturation levels if indicated, in the electronic medical record. Document oxygen saturation level/and or vital signs in the electronic medical record as indicated, and any unusual findings and follow-up interventions including provider and responsible party notification. On 5-9-24, at 12:00 PM, and on 5-10-24 at 12:00 PM, the Administrator and Corporate RN were made aware of the lack of respiratory assessments and oxygen administration for Resident #40. They stated they had nothing further to provide.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40711 Based in information obtained during the sufficient and competent nurse staffing task, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week which could potentially affect all residents. The findings included; During the nursing staff review from June 2022 through May 2024. The facility staff was unable to verify RN coverage for at least 8 consecutive days on the following dates for eleven (11) days: 7/03/23, 7/04/23, 7/05/23, 7/08/23,7/16/23, 8/05/23, 8/06/23, 9/09/23, 9/10/23, 10/15/23, and 10/22/23. The above dates were verified by the scheduling coordinator on 5/14/24 at approximately 11:30 AM. On 5/14/24 at approximately 3:30 p.m., the above findings were reviewed with the Administrator, Director of Nursing and Regional Nurse Consultant. The administrator said that coverage should have been provided.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31199

Based on Staff interview, clinical record review, and facility document review, the facility failed to provide medications as ordered by a physician for one (Resident #179) in a survey sample of 50 residents.

The findings included:

1. For Resident #179, Intravenous (IV) Antibiotics were unavailable during an acute post operative infection.

Resident #179, was admitted to the facility on [DATE] at 6:30 PM, and discharged on [DATE] after 8:00 AM. Diagnoses included; After care following joint replacement surgery, infection due to right knee internal prosthetic, hypertension, hyperthyroidism, obesity, and gastroesophageal reflux disease (GERD).

Resident #179's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-29-24 was coded as a discharge assessment. Resident #179 was coded as having no cognitive impairment. Resident #179 was also coded as requiring supervision or limited dependence on one staff member to perform activities of daily living, such as hygiene, transferring, and bed mobility.

The Resident's physician orders were reviewed and revealed an order for antibiotics. The order was for the following;

1-16-24 Penicillin G Potassium 20,000,000 units use 4 milliunit IV every 4 hours, start 1-16-24.

The Medication and Treatment Administration Record (MAR/TAR) was reviewed for January 2024, and revealed the absence of nursing signatures on some occasions, and a signature with the number 9 added to it indicating the antibiotic was not administered on 9 of 79 occasions. Those following doses included:

1-16-24 - 8:00 AM, 12:00 PM, 4:00 PM

1-17-24 - 4:00 AM

1-18-24 - 4:00 PM

1-24-24 - 12:00 PM

1-27-24 - 8:00 AM, 12:00 PM, 4:00 PM

Nursing medication administration notes do not indicate why the antibiotics were not administered as ordered, and why they were omitted. Only one nursing orders administration note existed in the clinical record completed by LPN J which documented medication not available, MD (doctor), RP (responsible party), nursing managers are aware medication has been stat ordered, on 1-16-24 at 6:53 PM.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guidance for the administration of Insulin is given by The National Institutes of Health (NIH), and is as follows; National Institutes of Health & Medline.gov: Antibiotics must be given as per a doctor's order and on the schedule indicated. If a dose is missed the doctor must be notified. Do not miss doses. Do not discontinue this medication without seeking a doctor's help. Stopping Antibiotics increases the likelihood of MDRO's (multi drug resistant organisms) such as Methycillin Resistant Staphyloccocus Aureus (MRSA), and can result in rebound infections which can be life threatening. Resident #179's care plan was reviewed and revealed no care plan for IV antibiotic infusions for an active infection. Nursing and physician progress notes were reviewed, and revealed no notes documenting that the medication had been unavailable, omitted, nor that the doctor was made aware of the omissions. Interviews conducted on 5-8-24, and 5-9-24 with nursing staff on both units revealed that the expectation for all medications is that they are available and administered per physician's order. They were in agreement that if there was a hole (no signature), or a 9 on the medication administration record (MAR), that the medication was not administered. On 5-10-24 at 11:00 a.m., the DON (director of nursing) and Administrator were interviewed in the conference room and stated that they had been unaware that medications had not been given, nor that the doctor and family were not notified of medications being omitted by staff. The DON was a new staff member and had recently been hired. On 5-13-24 at approximately 4:30 p.m., at the end of day debrief, the Administrator and DON were again made aware of the failure of staff to prevent significant medication errors in unavailable and omitted Antibiotics as ordered. No further information was provided.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to prevent significant medication errors for one Resident (Residents #179) in a survey sample of 50 Residents. The findings included: For Resident #179, the facility staff failed to administer Intravenous (IV) antibiotics after an infection from a status post knee replacement with acute hospitalization follow up for the post operative infection. Resident #179, was admitted to the facility on [DATE] at 6:30 PM, and discharged on [DATE] after 8:00 AM. Diagnoses included; After care following joint replacement surgery, infection due to right knee internal prosthetic, hypertension, hyperthyroidism, obesity, and gastroesophageal reflux disease (GERD). Resident #179's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-29-24 was coded as a discharge assessment. Resident #179 was coded as having no cognitive impairment. Resident #179 was also coded as requiring supervision or limited dependence on one staff member to perform activities of daily living, such as hygiene, transferring, and bed mobility. The Resident's physician orders were reviewed and revealed an order for antibiotics. The order was for the following; 1-16-24 Penicillin G Potassium 20,000,000 units use 4 milliunit IV every 4 hours, start 1-16-24. The Medication and Treatment Administration Record (MAR/TAR) was reviewed for January 2024, and revealed the absence of nursing signatures on some occasions, and a signature with the number 9 added to it indicating the antibiotic was not administered on 9 of 79 occasions. Those follow; 1-16-24 - 8:00 AM, 12:00 PM, 4:00 PM 1-17-24 - 4:00 AM 1-18-24 - 4:00 PM 1-24-24 - 12:00 PM 1-27-24 - 8:00 AM, 12:00 PM, 4:00 PM Nursing medication administration notes do not indicate why the antibiotics were not administered as ordered, and why they were omitted. Only one nursing orders administration note existed in the clinical record completed by LPN J which documented medication not available, MD (doctor), RP (responsible party), nursing managers are aware medication has been stat ordered, on 1-16-24 at 6:53 PM. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guidance for the administration of Insulin is given by The National Institutes of Health (NIH), and is as follows; National Institutes of Health & Medline.gov: Antibiotics must be given as per a doctor's order and on the schedule indicated. If a dose is missed the doctor must be notified. Do not miss doses. Do not discontinue this medication without seeking a doctor's help. Stopping Antibiotics increases the likelihood of MDRO's (multi drug resistant organisms) such as Methycillin Resistant Staphyloccocus Aureus (MRSA), and can result in rebound infections which can be life threatening. Resident #179's care plan was reviewed and revealed no care plan for IV antibiotic infusions for an active infection. Nursing and physician progress notes were reviewed, and revealed no notes documenting that the medication had been unavailable omitted, nor that the doctor was made aware of the omissions. Interviews conducted on 5-8-24, and 5-9-24 with nursing staff on both units revealed that the expectation for all medications is that they are available and administered per physician's order. They were in agreement that if there was a hole (no signature), or a 9 on the medication administration record (MAR), that the medication was not administered. On 5-10-24 at 11:00 a.m., the Director of Nursing (DON) and Administrator were interviewed in the conference room and stated that they had been unaware that medications had not been given, nor that the doctor and family were not notified of medications being omitted by staff. The DON was a new staff member and had recently been hired. On 5-13-24 at approximately 4:30 p.m., at the end of day debrief, the Administrator and DON were again made aware of the failure of staff to prevent significant medication errors in unavailable and omitted Antibiotics as ordered. No further information was provided.