STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens at Warwick Forest	1000 Old Denbeigh Boulevard Newport News, VA 23602

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 59 residents in the survey sample, Resident #122's choice to receive showers was honored. Resident #122 was dependent on staff for the provision of showers and had not received a shower from 12/6/19 through 2/19/20. The findings included: Resident #122 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The current MDS (Minimum Data Set) a significant change with an Assessment Reference Date of 1/31/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was coded as requiring extensive assistance of one staff for bed mobility, dependent on two staff for transfers, and dependent on one staff for bathing and showers. The resident was coded as having advanced pressure injuries to the sacrum and buttocks, two stage IV's (full thickness tissue loss with exposed bone, tendon or muscle), and one stage III (full thickness tissue loss). The person-centered comprehensive plan of care identified as a focus area that the resident required assistance of with ADL's (Activities of Daily Living), the goal listed was that the resident would be clean and dressed appropriately for facility activities through next review. One of the interventions was to assist with ADL's (bathing, grooming, toileting, feeding, ambulating) if resident is not able to complete. The care plan did not indicate the resident refused ADL care to include showers. During the initial tour of the facility on 2/18/20 at approximately 1:00 p.m., the resident was observed in bed. When asked if the facility staff provide showers he stated, I've only had a shower once since I've been here .I would love to take a shower, at least twice a week during the day shift around 10:00 a.m. He further stated that he believes a staff member told him he was not able to receive showers due to the pressure injuries. Review of the shower schedule evidenced the resident was scheduled for showers on Wednesdays and Saturdays on the 3 PM-11 PM shift. (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: 495071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation of the ADL Verification Worksheets dated from 12/6/19 through 2/19/20 were provided for review. The worksheets evidenced the resident refused a shower on 12/11/19, 12/15/19, and 1/11/20. The worksheets failed to evidence any documentation of the resident receiving a shower from 12/6/19 through 2/19/20. On 2/20/20 at 9:57 a.m., the RN (Registered Nurse) unit manager was interviewed. The above findings was shared. She stated she had been the unit manager on this unit for eight days. She stated, I did not know he was not getting showers. She stated she spoke with the resident last evening and the resident told her that he was offered a shower a couple of times. She stated, He will get one today even if I have to give it to him myself .if he refuses we will care plan it. When asked if the pressure injuries would have prevented the resident from having received showers she stated,No. The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting conducted on 2/21/20. No additional information was provided prior to exit.

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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 - Some	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** Based on record review and staff interviews, the facility staff failed to ensure eight residents (Residents #48, #135, #39, #46, #77, #138, #52, and #91, were given the opportunity to formulate an advance directive in the survey sample of 59 residents. The findings included: 1. The facility staff failed to ensure Resident #48 had the opportunity to formulate an advance directive. Resident #48 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of the clinical record for Resident #48, no advance directive was included in the resident record. During an interview on [DATE] at 12:08 PM with the Director of Nursing , she stated, the resident does not have an advance directive. 2. The facility staff failed to ensure Resident #135 had the opportunity to formulate an advance directive. Resident #135 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of the clinical record for Resident #135, no advance directive was included in the resident record. During an interview on [DATE] 12:14 PM with the Director of Nursing, she stated, the resident does no have an advance directive. 3. For Resident #39, the facility staff failed to ensure that a copy of the residents advance directive was accessible in the medical record. Resident #39 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #39's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of [DATE] was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severely cognitive skills for daily decision making. On [DATE] at 1:05 p.m., review of the clinical record revealed the following in the front of the record: Virginia Physician order [REDACTED]. Review of the clinical record on [DATE] at 1:05 p.m., revealed that Resident #39 did not have an advance directive documented in the clinical record. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 4:00 p.m., an interview was conducted with OSM (Other Staff Member) #1, the Admissions Tech, and when asked to explain the process for reviewing information concerning advance directives with residents, Admissions Tech stated, I review #11 in the Admission Agreement with the resident and / or resident representative and she read the following: Provide information and assistance to the Resident to establish an advance medical directive; provided, however, that such assistance is not and shall not be deemed to be or include providing legal advice to the Resident. The Admissions Tech stated, I also review Advance Directive Information form with the resident and / or resident representative and they complete and sign it. If they have a advance directive they are asked to bring a copy in and I scan it into Vision. If they don't have an advance directive they are given the Discussion Guide and Workbook and they the resident, family take it and complete it. When asked what was done if the resident or family was asked to bring a copy of their advance directive in and they did not, Admissions Tech stated, I try to follow up with them. Requested copy of Advance Directive Information form reviewed with Resident #39 and copy of advance directives. On [DATE] at approximately 12:04 p.m., received copy of Advanced Directive Information form dated [DATE]. Review of the form revealed that the following was elected on the form by the Resident Representative: I do have an Advance Directive; I have provided a copy of my Advance Directive to the facility. On [DATE] requested copy of Resident #39's Advance Directive. The facility provided a copy of the POST form dated [DATE]. The Administrator, Director of Nursing and Senior Director was informed of the finding on [DATE] at approximately 5:30 p.m. The facility did not present any further information about the finding. 4. For Resident #46, the facility staff failed to establish a written description of the facility's policies and procedures on advance directives. Resident #46 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #46's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of [DATE] was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #46 as requiring extensive assistance of 1 for personal hygiene, extensive assistance of 2 for toilet use, total dependence of 1 for eating and bathing, total dependence of 2 for bed mobility, transfer and dressing. On [DATE] at 10:08 a.m., review of Resident #46's clinical record revealed the following: Full Code order dated [DATE]. Review of clinical record did not reveal evidence of a advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 4:00 p.m., an interview was conducted with OSM (Other Staff Member) #1, the Admissions Tech, and when asked to explain the process for reviewing information concerning advance directives with residents, Admissions Tech stated, I review #11 in the Admission Agreement with the resident and / or resident representative and she read the following: Provide information and assistance to the Resident to establish an advance medical directive; provided, however, that such assistance is not and shall not be deemed to be or include providing legal advice to the Resident. The Admissions Tech stated, I also review Advance Directive Information form with the resident and / or resident representative and they complete and sign it. If they have a advance directive they are asked to bring a copy in and I scan it into Vision. If they don't have an advance directive they are given the Discussion Guide and Workbook and they the resident, family take it and complete it. When asked what was done if the resident or family was asked to bring a copy of their advance directive in and they did not, Admissions Tech stated, I try to follow up with them. Requested copy of Advance Directive Information form reviewed with Resident #46 and copy of advance directives. On [DATE] at approximately 12:00 p.m., received copy of Advance Directive Information form dated [DATE] indicating that Resident #46 did not have an advance directive; copy of Physician order [REDACTED]. Review of the Advance Directive revealed that the last name on the Advance Directive did not match Resident #46's last name. On [DATE] at approximately 12:30 p.m., an interview was conducted with OSM #5, Social Worker, and when she was asked to explain why the name on the Advance Directive did not match the last name of Resident #46, The Social Worker stated, I will speak with the resident. On [DATE] at approximately 2:00 p.m., the Social Worker stated, OSM #9, Business Office Assistant, and I went down to (Resident Name) and asked her about the last name on her Advance Directive. (Resident Name) stated that the resident is a quadriplegic and that OSM #10, residents cousin, her responsible party, filled out the paper work and wrote her name on the Advance Directive form. Stated that the resident stated that she had been married for [AGE] years and her last name is (Current last name) and don't know why she wrote her maiden name. Requested written statement concerning Social Workers conversation with Resident #46. On [DATE] at approximately 2:00 p.m., an interview was conducted with the Administrator and when asked for a copy of the facility policy and procedure on advance directives, the Administrator stated, We do not have a policy and procedure on advance directives. On [DATE] at approximately 3:00 p.m., received copy of Resident Note Entry dated [DATE] from the Social Worker. Review of Resident Note Entry revealed the following: Social Worker inquired of Resident #46 if her previous name was . She stated that was her maiden name and that her last name has been for the past [AGE] years. Social Worker than showed (Resident Name) the Advance Directive and Durable POA (Power Of Attorney) forms that were signed on [DATE] that have her last name as Resident #46 stated that (Business Office Assistant Name) completed these forms because she is unable to use her hands. Social Worker then asked for clarification from Business Office Assistant who reported that the forms were completed by Resident #46's cousin whose last name is also . She further stated that she only witnessed Resident #46's wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator, Director of Nursing and Senior Director was informed of the finding on [DATE] at approximately 5:30 p.m. The Administrator stated, I don't believe we are required to have a policy and procedure for advance directives. We have a process. Copy of process was requested. The facility did not present any further information about the finding. 5. For Resident #77, the facility staff failed to ensure that a copy of the residents advance directive was in the clinical record. Resident #77 was admitted to the facility on [DATE], discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #77's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of [DATE] was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. Review of Resident #77's clinical record on [DATE] at 1:07 p.m. revealed that there was no advance directive in the clinical record. On [DATE] at approximately 4:00 p.m., an interview was conducted with OSM (Other Staff Member) #1, the Admissions Tech, and when asked to explain the process for reviewing information concerning advance directives with residents, Admissions Tech stated, I review #11 in the Admission Agreement with the resident and / or resident representative and she read the following: Provide information and assistance to the Resident to establish an advance medical directive; provided, however, that such assistance is not and shall not be deemed to be or include providing legal advice to the Resident. The Admissions Tech stated, I also review Advance Directive Information form with the resident and / or resident representative and they complete and sign it. If they have a advance directive they are asked to bring a copy in and I scan it into Vision. If they don't have an advance directive they are given the Discussion Guide and Workbook and they the resident, family take it and complete it. When asked what was done if the resident or family was asked to bring a copy of their advance directive in and they did not, Admissions Tech stated, I try to follow up with them. Requested copy of Advance Directive Information form reviewed with Resident #46 and copy of advance directives. On [DATE] at approximately 12:04 p.m., received copy of Advanced Directive Information form dated [DATE]. Review of the form revealed that the following was elected on the form by the Resident Representative: I do have an Advance Directive; and I have not provided a copy of my Advance Directive to the facility. The Administrator, Director of Nursing and Senior Director was informed of the finding on [DATE] at approximately 5:30 p.m. The facility did not present any further information about the findings. 6. The facility staff failed to implement Resident #138's wishes to change his Advance Directive from a full code to a DNR (do not resuscitate). Resident #138 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of [DATE] coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan dated [DATE] identified the resident was a Full Code. The care plan was reviewed during a care plan meeting conducted on [DATE] with the Interdisciplinary Team, to include the Social Worker, Nurse Practitioner, Registered Dietician and Unit Coordinator. The meeting notes read in part, (Resident name) and his wife were in attendance. Code status and face sheet were reviewed. (Resident name) wishes to change his code status from a full code to a DNR. Nurse Practitioner to address. Review of the clinical record on [DATE] evidenced a Virginia Physician order [REDACTED]. This form is a Physician order [REDACTED]. Section A. Cardiopulmonary Resuscitation (CPR) was checked for Attempt Resuscitation. There was no updated POST orders in the clinical record to change the code status per the resident's wishes from a full code to a DNR. On [DATE] at 9:30 a.m., Resident #138 was observed sitting in a motorized wheelchair at the bedside. The resident was asked about his wishes to change his code status from a full code to a DNR, he stated, I thought I made it clear, I don't want to be resuscitated. On [DATE] at 9:43 a.m., the Licensed Practical Nurse (LPN#6) who was assigned to care for the resident was asked what was the resident's code status. She reviewed the assignment sheet that had the code status of each resident on her assignment and stated, full code. On [DATE] at approximately 10:30 a.m., the Social Worker was interviewed. She was asked what was the current code status of Resident #138. She stated it would be found in the front of the clinical record on the unit. She reviewed the electronic record and stated the resident was a Full Code. She stated she recalled that during the care plan meeting conducted on [DATE] that there was a lengthy discussion with the resident and the wife about the resident's wishes to change the code status. She stated, It was an important discussion. She also stated the Nurse Practitioner had documented on [DATE] that a new POST was completed and the resident was a DNR-comfort measures. A second review of the clinical record on the unit was conducted following the meeting with the Social Worker. There was no updated POST dated [DATE] found. On [DATE] at approximately 1:00 p.m., the facility located the current POST form dated [DATE] inside the physicians office located in the facility. The POST form had not been forwarded to the nursing department to implement the residents wishes until identified by this inspector. On [DATE] during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing. No additional information was provided prior to exit. 7. The facility staff failed to ensure Resident #52 was given the opportunity to formulate an Advance Directive. Resident #52 was originally admitted to the nursing facility on [DATE]. [DIAGNOSES REDACTED]. Review of the clinical record revealed that there was no Advance Directive for Resident #52. Review of Resident #52's Physician order [REDACTED]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 9:35 a.m., an interview was conducted with the Admission Technician. The Admission Technician was asked if Resident #52 was given the opportunity to formulate an Advance Directive. She stated, I will have to review his clinical record and get back with you. On the same day at approximately 9:55 a.m., the Admission Technician said she was unable to locate an Advance Directive in Resident #52's clinical record. The Admission Technician said when a resident is admitted to the nursing facility, part of their admission process includes reviewing and discussing Advance Care Planning. The Admission Technician provided a blank document titled Advance Directive Information. The document included but not limited to: -I do or do not have an Advance Directive (check correct box). -I have or have not provided a copy of my Advance Directive to the facility (check correct box). -By initialing, you acknowledge you have received (name of facility) information regarding Advance Directive. On [DATE] at approximately 10:00 a.m., the surveyor asked the Admission Technician if there was a signed acknowledge form located in Resident #52's. The Admission Technician stated, No, I was not able to locate any information that anyone gave Resident #52 the opportunity to formulate an Advance. A briefing was held with the Director of Nursing and Cooperate Nurse on [DATE] at approximately 4:00 p.m. The facility did not present any further information about the findings. 8. The facility staff failed to ensure Resident #91 was given the opportunity to formulate an Advance Directive. Resident #91 was originally admitted to the nursing facility on [DATE]. [DIAGNOSES REDACTED]. Review of the clinical record revealed that there was no Advance Directive for Resident #91. Review of Resident #91's Physician order [REDACTED]. On [DATE] at approximately 9:35 a.m., an interview was conducted with the Admission Technician. The Admission Technician was asked if Resident #91 was given the opportunity to formulate an Advance Directive. She stated, I will have to review his clinical record and get back with you. On the same day at approximately 9:55 a.m., the Admission Technician said she was unable to locate an Advance Directive in Resident #91's clinical record. The Admission Technician said when a resident is admitted to the nursing facility, part of their admission process includes reviewing and discussing Advance Care Planning. The Admission Technician provided a blank document titled Advance Directive Information. The document included but not limited to: -I do or do not have an Advance Directive (check correct box). -I have or have not provided a copy of my Advance Directive to the facility (check correct box). -By initialing, you acknowledge you have received (name of facility) information regarding Advance Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 10:00 a.m., the surveyor asked the Admission Technician if there was a signed acknowledge form located in Resident #91's. The Admission Technician stated, No, I was not able to locate any information that anyone gave Resident #91 the opportunity to formulate an Advance. A briefing was held with the Director of Nursing and Cooperate Nurse on [DATE] at approximately 4:00 p.m. The facility did not present any further information about the findings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview and staff interviews the facility staff failed to maintain a clean, sanitary and homelike environment for 1 of 59 residents (Resident #109) in the survey sample. The findings included: Resident #109's, wheel chair observed with worn, torn and cracked armrest pads. Resident #109 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The current Minimum Data Set (MDS), quarterly assessment with an Assessment Reference Date (ARD) of 01/02/20 coded the resident with a 01 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. In addition, the MDS coded Resident #109 requiring total dependence of one bathing, extensive assistance of two with bed mobility, dressing, transfer and toilet use, extensive assistance of one with hygiene. The MDS was coded under section G 0600 (mobility devices) was coded for wheel chair usage. Resident #109's person-centered comprehensive care plan documented Resident #109 requires assistance with transfers and locomotion. The goal: resident will maintain current level of functioning and will not demonstrate unavoidable function decline. Some of the intervention/approaches to manage goal include the use of a manual wheelchair. On initial tour of the facility on 02/18/20 at approximately 11:49 a.m. Resident #109 was observed sitting up in his wheel chair. Resident #109's wheel chair was observed with worn, torn and cracked armrest pads. On 02/19/20 at approximately 11:35 a.m., Resident #109 was observed in the hallway sitting in his wheel chair. The wheel chair armrest pads to Resident #109's wheel chair remains unchanged; worn, torn and cracked. On the same day at approximately 4:20 p.m., the Director of Maintenance , with the surveyor present, assessed Resident #109's wheel chair armrest pad. The Maintenance Director said as we approached Resident #109, I can see it already (referring to Resident #109's wheel chair armrest pads). He said Resident #109's wheel chair armrest pads need to be replaced. The Maintenance Director said someone should have put in a work order for maintenance to replace Resident #109's wheel chair armrest pads. On 02/20/20 at approximately 12:05 p.m., Resident #109's bilateral wheelchair armrest pads were replaced. A briefing was held with the Director of Nursing and Cooperate Nurse on 02/21/20 at approximately 4:00 p. m. The facility did not present any further information about the findings.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on clinical record reviews, staff interviews, and facility documentation review; the facility's staff failed to covey a copy of the resident's comprehensive care plan goals to the receiving facility for 8 of 59 residents (Resident #80, #40, #125, #43, #63, #121, #3 and #77) in the survey sample. 1. The facility staff failed to convey the summary and goals of the comprehensive plan of care upon transfer/discharge to the local hospital for Resident #80. Resident #80 was admitted to the nursing facility on 10/28/11 with [DIAGNOSES REDACTED]. Resident #80's most recent Minimum Data Set (MDS) was a quarterly assessment and coded the resident with short and long term memory problems and severely impaired in the cognitive skills for daily decision making. There was no evidence provided that the facility staff conveyed the summary and goals of the comprehensive plan of care upon or after transfer/discharge to the local hospital's Emergency Department on 2/13/20, 10/11/19, 7/9/19, 4/2/19, 3/1/19, 2/28/19, 8/20/18 and 8/8/18. On 2/21/20 at approximately 3:00 p.m., Licensed Practical Nurse (LPN) #10 stated that the nurses were inserviced on 2/20/20 regarding the process to follow whenever a resident is transferred to the hospital and all the paperwork that is supposed to be sent and or faxed over to the hospital. On 2/21/20 at approximately 4:30 p.m., the Director of Nursing (DON) and two corporate nurses stated they could provide time stamp for Resident #80's discharge from the facility and expected that the nursing staff follow a check list of items that needed to be sent with the resident or forwarded to the receiving entity upon transfers to the ED to include the care plan summary and goals, but there was no evidence that the information was sent. The facility did not have a facility policy and procedures that addressed transfer and discharge information to communicate to the receiving health care institution or provider. 2. The facility staff failed to convey the summary and goals of the comprehensive plan of care upon transfer/discharge to the local hospital for Resident #40. Resident #40, was admitted to the nursing facility on 5/29/19 with [DIAGNOSES REDACTED]. Resident #40's most recent Minimum Data Set (MDS) was a quarterly assessment and coded the resident with a score of 00 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the necessary cognitive skills for daily decision making. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Gardens at Warwick Forest		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Old Denbeigh Boulevard Newport News, VA 23602	

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no evidence provided that the facility staff conveyed the summary and goals of the comprehensive plan of care upon or after transfer/discharge to the local hospital's Emergency Department on 6/5/19. On 2/21/20 at approximately 3:00 p.m., Licensed Practical Nurse (LPN) #10 stated that the nurses were inserviced on 2/20/20 regarding the process to follow whenever a resident is transferred to the hospital and all the paperwork that is supposed to be sent and or faxed over to the hospital. On 2/21/20 at approximately 4:30 p.m., the Director of Nursing (DON) and two corporate nurses stated they could provide time stamp for Resident #40's discharge from the facility and expected that the nursing staff follow a check list of items that needed to be sent with the resident or forwarded to the receiving entity upon transfers to the ED to include the care plan summary and goals, but there was no evidence that the information was sent. 3. The facility staff failed to convey the summary and goals of the comprehensive plan of care upon transfer/discharge to the local hospital for Resident #125. Resident #125, was admitted to the nursing facility on 3/24/17 with [DIAGNOSES REDACTED]. Resident #125's most recent Minimum Data Set (MDS) was a quarterly and coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the skills for daily decision making. There was no evidence provided that the facility staff conveyed the summary and goals of the comprehensive plan of care upon or after transfer/discharge to the local hospital's Emergency Department on 2/17/19. On 2/21/20 at approximately 3:00 p.m., Licensed Practical Nurse (LPN) #10 stated that the nurses were inserviced on 2/20/20 regarding the process to follow whenever a resident is transferred to the hospital and all the paperwork that is supposed to be sent and or faxed over to the hospital. On 2/21/20 at approximately 4:30 p.m., the Director of Nursing (DON) and two corporate nurses stated they could provide time stamp for Resident #125's discharge from the facility and expected that the nursing staff follow a check list of items that needed to be sent with the resident or forwarded to the receiving entity upon transfers to the ED to include the care plan summary and goals, but there was no evidence that the information was sent. 4. Resident #43 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #43's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 11/27/19. Resident was coded on the Staff Interview for Mental Status Exam (Section C100) as being able to make decisions independently. Review of Resident #43's clinical record revealed that he was transferred to the hospital on [DATE]. The following nursing note was written: 11:15 (a.m.) Resident is sitting up at the nurses station and suddenly becomes unresponsive to verbal and physical commands . 911 emergency transport was called, the residents family notified, and report was given to the EMT (emergency medical transport) and ER (emergency room) nurses. The was resident was transported to (Name of Hospital). There was no evidence that care plan goals were sent with the resident upon transfer to the hospital. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #43's clinical record revealed that he was arrived back to the facility that same day on 2/11/20. On 2/20/20 at 11:31 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #1 stated that she will send the facesheet, MARS (medication administration record), and TARs (treatment administration record). LPN #1 stated that she had not worked at the facility long and has only been in that situation once. LPN #1 stated that she would ask another nurse for any additional documents that need to be sent. LPN #1 stated she would also notify the emergency room and give a report. When asked if care plan goals or the care plan was sent with residents upon transfer to the hospital, LPN #1 stated that she was not sure. On 2/20/20 at 12:04 p.m., an interview was conducted with LPN #3, the clinical coordinator. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #3 stated that nurses should be sending the facesheet, code status information, list of medications, and the SBAR (situation, background, assessment, and recommendation). When asked if care plan goals were sent, LPN #3 stated, We do. When asked how this writer would know what items were sent with the resident upon transfer, LPN #3 stated that it should be documented. LPN #3 was asked to provide any evidence that care plan goals were sent with Resident #43 upon transfer to the hospital on [DATE]. On 2/20/20 at 2:12 p.m., LPN #3 stated that she could not provide evidence the care plan goals were sent with Resident #43 upon transfer to the hospital. On 2/20/20 at 4:38 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 5. Resident # 63 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #63's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 12/8/19. Resident #63 was coded in Section C (Cognitive Function) as being severely impaired in cognitive function scoring 05 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #63's clinical record revealed that he had been sent to the hospital on [DATE] and arrived back to the facility on [DATE] with a [DIAGNOSES REDACTED]. There was no evidence in his clinical record that the care plan goals were sent with Resident #63 upon transfer to the hospital. On 2/20/20 at 11:31 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #1 stated that she will send the facesheet, MARS (medication administration record), and TARs (treatment administration Record). LPN #1 stated that she had not worked at the facility long and has only been in that situation once. LPN #1 stated that she would ask another nurse for any additional documents that need to be sent. LPN #1 stated she would also notify the emergency room and give a report. When asked if care plan goals or the care plan was sent with residents upon transfer to the hospital, LPN #1 stated that she was not sure. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/20 at 12:04 p.m., an interview was conducted with LPN #3, the clinical coordinator. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #3 stated that nurses should be sending the facesheet, code status information, list of medications, and the SBAR (situation, background, assessment, and recommendation). When asked if care plan goals were sent, LPN #3 stated, We do. When asked how this writer would know what items were sent with the resident upon transfer, LPN #3 stated that it should be documented. LPN #3 was asked to provide any evidence that care plan goals were sent with Resident #63 upon transfer to the hospital on [DATE]. On 2/20/20 at 2:12 p.m., LPN #3 stated that she could not provide evidence that the care plan goals were sent with Resident #63 upon transfer to the hospital. On 2/21/20 at 4:38 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 6. The facility staff failed to send the required care plan goals upon transfer to the ER for Resident #121. Resident #121 was admitted to the facility on [DATE] with a readmission date of [DATE] following a hospitalization for surgical intervention to the left proximal femur resulting from a fall from the bed on 12/25/19 at the facility. The resident's other [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) prior to the fall was a quarterly with an Assessment Reference Date of 12/11/19. The resident was coded as scoring an 11 out of a possible 15 on the Brief Interview for Mental Status indicating the resident had moderately impaired daily decision making skills. A review of the clinical record evidenced the resident had a witnessed fall from the bed during ADL (activities of daily living) care on 12/25/19. As a result of the fall the resident sustained [REDACTED]. The resident was transferred to the emergency room for evaluation and was admitted . The clinical record failed to evidence documentation that the comprehensive care plan goals were sent with the resident upon transfer or provided to the hospital after admission to ensure a safe and effective transition of care. The facility's Nursing Home to Hospital Transfer Form for Resident #121's transfer on 12/26/19 was reviewed . On page five of seven was a section for the staff to document the Primary Goals of Care at Time of Transfer. This section was blank, not signed or dated by the staff. On page seven of seven was the Acute Care Transfer Document Checklist, this from was not complete, did not list the documents that were sent with the resident upon transfer or signed by the staff. The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting conducted on 2/21/20. The facility did not provide any additional information or documentation prior to exit. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Resident #3 was originally admitted to the facility on [DATE]. Resident #3 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set (MD'S - an assessment protocol) with an Assessment Reference date of 11/05/2019 coded Resident #3 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #3 as requiring supervision with setup help only for eating, extensive assistance of 1 for bed mobility, transfer, dressing, and personal hygiene, extensive assistance of 2 for toilet use and total dependence of 1 for bathing. On 02/18/2020 requested evidence that Resident #3's Care Plan Goals were sent with the resident upon discharge to the hospital on [DATE]. On 02/18/2020 at approximately 6:00 p.m., the Administrator provided copy of Nursing Home to Hospital Transfer Form, Acute Care Transfer Document Checklist and SBAR Communication Form and Progress Note dated 11/27/2019. Review of the forms did not reveal documentation evidencing that care plan goals were included. On 02/19/2020 at 5:15 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #5. When LPN #5 was asked what documentation was sent with residents when discharged to the hospital, LPN #5 stated, I send the face sheet, medication list, DNR (Do Not Resuscitate), SBAR, Transfer Form, Bed Hold Policy, Discharge Form and copy of doctors order, recent labs, x-rays and clinical nursing notes. When asked if she sends the residents care plan goals, LPN #5 stated, Don't know. An interview was conducted with LPN #10 on 02/19/2020 at approximately 5:20 p.m., when LPN #10 was asked what was the process for sending a resident out to the hospital and what documentation she sends when discharging a resident to the hospital, LPN #10 stated, I call the doctor for an order, I go to the LTC (Long Term Care) process LOA (Leave of Absence) to the hospital in the computer. I print the SBAR, order, call 911, call transportation, notify the RP (Responsible Party), print the transfer Form, face sheet, print immediate discharge, MAR (Medication Administration Record), TAR (Treatment Administration Record) clinical notes, Clinical Summary Report, Bed Hold Policy. We fill out the Bed Hold Policy but we don't usually send it. I send all the orders, the POST - the code status. On 2/20/2020 review of Resident #3's clinical notes dated 11/27/2020 did not reveal documentation evidencing that the residents Care Plan Goals were sent upon the residents discharge to the hospital. Requested and received copy of facility transfer and discharge policy on 02/21/2020. The Administrator, Director of Nursing and Senior Director was informed of the finding on 02/21/2020 at approximately 5:30 p.m. at the pre-exit meeting. When the Director of Nursing was asked what her expectations are of the nurses sending Care Plan Goals and Bed Hold Notices, The Director of Nursing stated, I expect the nurses to send the residents Care Plan Goals and Bed Hold Notices at the time of discharge and to document in the progress notes that they were sent. The facility did not present any further information about the finding. The facility policy titled - LHARS (Lifelong Health & Aging Related Services) - ADM (Administration) - Nursing Home Discharge/Transfer Policy (Effective Date - 12/11/2019) Policy Statement: It is the goal of the facility to provide a safe departure from the facility and provide sufficient information for after care of the resident. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The hospital or receiving facility will be provided with all applicable state and federal notices at the time of transfer as soon as possible for emergent discharges/transfers. These notices include: Care Plan Goals (this can be included in the interact form, a separate document, resident's full care plan or baseline care plan if a comprehensive care plan has not been completed yet). 8. Resident #77 was admitted to the facility on [DATE], discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #77's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/14/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #77 as requiring extensive assistance of 1 for bed mobility, transfer, dressing, eating, toilet use and personal hygiene and total dependence of 2 for bathing. On 02/18/2020 evidence that Resident #77's Care Plan Goals were sent with the resident upon discharge to the hospital on [DATE] was requested. On 02/18/2020 at approximately 6:30 p.m., received copy of Resident #77's Clinical Summary with admission date of [DATE] with list of Care Plan Interventions. No documentation evidencing that Care Plan Interventions were sent with resident upon discharge to the hospital on [DATE]. On 02/19/2020 at 5:15 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #5. When LPN #5 was asked what documentation was sent with residents when discharged to the hospital, LPN #5 stated, I send the face sheet, medication list, DNR (Do Not Resuscitate), SBAR, Transfer Form, Bed Hold Policy, Discharge Form and copy of doctors order, recent labs, x-rays and clinical nursing notes. When asked if she sends the residents care plan goals, LPN #5 stated, Don't know. An interview was conducted with LPN #10 on 02/19/2020 at approximately 5:20 p.m., when LPN #10 was asked what was the process for sending a resident out to the hospital and what documentation she sends when discharging a resident to the hospital, LPN #10 stated, I call the doctor for an order, I go to the LTC (Long Term Care) process LOA (Leave of Absence) to the hospital in the computer. I print the SBAR, order, call 911, call transportation, notify the RP (Responsible Party), print the transfer Form, face sheet, print immediate discharge, MAR (Medication Administration Record), TAR (Treatment Administration Record) clinical notes, Clinical Summary Report, Bed Hold Policy. We fill out the Bed Hold Policy but we don't usually send it. I send all the orders, the POST - the code status. On 2/20/2020 review of Resident #77's clinical notes dated 12/03/2019 did not reveal documentation evidencing that the residents Care Plan Goals were sent with the resident upon discharge to the hospital. Requested and received copy of facility transfer and discharge policy on 02/21/2020. The Administrator, Director of Nursing and Senior Director was informed of the finding on 02/21/2020 at approximately 5:30 p.m. at the pre-exit meeting. When the Director of Nursing was asked what her expectations are of the nurses sending Care Plan Goals and Bed Hold Notices, The Director of Nursing stated, I expect the nurses to send the residents Care Plan Goals and Bed Hold Notices at the time of discharge and to document in the progress notes that they were sent. The facility did not present any further information about the finding. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled - LHARS (Lifelong Health & Aging Related Services) - ADM (Administration) - Nursing Home Discharge/Transfer Policy (Effective Date - 12/11/2019) Policy Statement: It is the goal of the facility to provide a safe departure from the facility and provide sufficient information for after care of the resident. The hospital or receiving facility will be provided with all applicable state and federal notices at the time of transfer as soon as possible for emergent discharges/transfers. These notices include: Care Plan Goals (this can be included in the interact form, a separate document, resident's full care plan or baseline care plan if a comprehensive care plan has not been completed yet).

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the residents representative in writing how long the nursing home will hold the residents bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to provide evidence that the written bed hold notification/policy was sent with three of 59 sampled residents, Residents #3, #77, and #63, upon transfer to the hospital. The findings included: 1. Resident #3 was originally admitted to the facility on [DATE]. Resident #3 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set (MD'S - an assessment protocol) with an Assessment Reference date of 11/05/2019 coded Resident #3 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. On 02/18/2020 evidence that written Bed Hold Notice was sent with Resident #3 upon discharge to the hospital on [DATE] was requested. On 02/18/2020 at approximately 6:00 p.m., the Administrator provided copy of Nursing Home to Hospital Transfer Form, Acute Care Transfer Document Checklist. and SBAR Communication Form and Progress Note dated 11/27/2019. Review of the forms did not reveal any documentation evidencing that Bed Hold Notice was sent with or provided to the resident upon discharge to the hospital. The Administrator stated, We are still looking for evidence that the Bed Hold Notice was sent. On 02/19/2020 at 5:15 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #5. When LPN #5 was asked what documentation is sent with residents when discharged to the hospital, LPN #5 stated, I send the face sheet, medication list, DNR (Do Not Resuscitate), SBAR, Transfer Form, Bed Hold Policy, Discharge Form and copy of doctors order, recent labs, x-rays and clinical nursing notes. An interview was conducted with LPN #10 on 02/19/2020 at approximately 5:20 p.m., when LPN #10 was asked what was the process for sending a resident out to the hospital and what documentation does she send when discharging a resident to the hospital, LPN #10 stated, I call the doctor for an order, I go to the LTC (Long Term Care) process LOA (Leave of Absence) to the hospital in the computer. I print the SBAR, order, call 911, call transportation, notify the RP (Responsible Party), print the transfer Form, face sheet, print immediate discharge, MAR (Medication Administration Record), TAR (Treatment Administration Record) clinical notes, Clinical Summary Report, Bed Hold Policy. We fill out the Bed Hold Policy but we don't usually send it. I send all the orders, the POST - the code status. On 2/20/2020 review of Resident #3's clinical notes dated 11/27/2020 did not reveal any documentation evidencing that the written Bed Hold Notice was sent with or provided to the resident upon discharge to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator, Director of Nursing and Senior Director was informed of the finding on 02/21/2020 at approximately 5:30 p.m. at the pre-exit meeting. When the Director of Nursing was asked what her expectations are of the nurses sending Care Plan Goals and Bed Hold Notices, The Director of Nursing stated, I expect the nurses to send the residents Care Plan Goals and Bed Hold Notices at the time of discharge and to document in the progress notes that they were sent. The facility did not present any further information about the finding. The facility policy titled - LHARS (Lifelong Health & Aging Related Services) - ADM (Administration) - Nursing Home Discharge/Transfer Policy (Effective Date - 12/11/2019) Policy Statement: It is the goal of the facility to provide a safe departure from the facility and provide sufficient information for after care of the resident. The hospital or receiving facility will be provided with all applicable state and federal notices at the time of transfer as soon as possible for emergent discharges/transfers . 2. Resident #77 was admitted to the facility on [DATE], discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #77's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/14/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. On 02/18/2020 evidence that written Bed Hold Notice was sent with Resident #77 upon discharge to the hospital on [DATE] was requested. On 02/18/2020 at approximately 6:30 p.m., received copy of document titled Notice of Bed Hold Policy to Resident, Responsible Family, or Legal Representative for Resident #77. No documentation evidencing that written Bed Hold Policy was provided to or sent with resident upon discharge to the hospital on [DATE]. On 02/19/2020 at 5:15 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #5. When LPN #5 was asked what documentation was sent with residents when discharged to the hospital, LPN #5 stated, I send the face sheet, medication list, DNR (Do Not Resuscitate), SBAR, Transfer Form, Bed Hold Policy, Discharge Form and copy of doctors order, recent labs, x-rays and clinical nursing notes. An interview was conducted with LPN #10 on 02/19/2020 at approximately 5:20 p.m., when LPN #10 was asked what was the process for sending a resident out to the hospital and what documentation she sends when discharging a resident to the hospital, LPN #10 stated, I call the doctor for an order, I go to the LTC (Long Term Care) process LOA (Leave of Absence) to the hospital in the computer. I print the SBAR, order, call 911, call transportation, notify the RP (Responsible Party), print the transfer Form, face sheet, print immediate discharge, MAR (Medication Administration Record), TAR (Treatment Administration Record) clinical notes, Clinical Summary Report, Bed Hold Policy. We fill out the Bed Hold Policy but we don't usually send it. I send all the orders, the POST - the code status. On 2/20/2020 review of Resident #77's clinical notes dated 12/03/2019 did not reveal documentation evidencing written Bed Hold Notice was sent with the resident upon discharge to the hospital. Requested and received copy of facility transfer and discharge policy on 02/21/2020. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator, Director of Nursing and Senior Director was informed of the finding on 02/21/2020 at approximately 5:30 p.m. at the pre-exit meeting. When the Director of Nursing was asked what her expectations are of the nurses sending Care Plan Goals and Bed Hold Notices, The Director of Nursing stated, I expect the nurses to send the residents Care Plan Goals and Bed Hold Notices at the time of discharge and to document in the progress notes that they were sent. The facility did not present any further information about the finding. The facility policy titled - LHARS (Lifelong Health & Aging Related Services) - ADM (Administration) - Nursing Home Discharge/Transfer Policy (Effective Date - 12/11/2019) Policy Statement: It is the goal of the facility to provide a safe departure from the facility and provide sufficient information for after care of the resident. The hospital or receiving facility will be provided with all applicable state and federal notices at the time of transfer as soon as possible for emergent discharges/transfers . 3. Resident # 63 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #63's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 12/8/19. Resident #63 was coded in Section C (Cognitive Function) as being severely impaired in cognitive function scoring 05 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #63's clinical record revealed that he had been sent to the hospital on [DATE] and arrived back to the facility on [DATE] with a [DIAGNOSES REDACTED]. There was no evidence in his clinical record that the bed hold policy was sent with Resident #63 upon transfer to the hospital. On 2/20/20 at 11:31 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #1 stated that she will send the facesheet, MARS (medication administration record), and TARs (treatment administration record). LPN #1 stated that she had not worked at the facility long and has only been in that situation once. LPN #1 stated that she would ask another nurse for any additional documents that need to be sent. LPN #1 stated she would also notify the emergency room and give a report. When asked if a bed hold policy was sent with residents upon transfer to the hospital, LPN #1 stated that she was not sure. On 2/20/20 at 12:04 p.m., an interview was conducted with LPN #3, the clinical coordinator. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #3 stated that nurses should be sending the facesheet, code status information, list of medications, and the SBAR (situation, background, assessment, and recommendation). When asked if the bed hold policy was sent, LPN #3 stated that they normally do send the bed hold policy. LPN #3 was asked to provide any evidence that care plan goals were sent with Resident #63 upon transfer to the hospital on [DATE]. On 2/20/20 at 2:12 p.m., LPN #3 stated that she could not provide evidence that the bed hold policy was sent with Resident #63 upon transfer to the hospital. On 2/21/20 at 4:38 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and facility document review the facility staff failed to ensure a baseline care plan was person-centered to include hospice services for 1 of 59 Residents in the Survey Sample, Resident #442. The findings included: Resident #442 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Due to Resident #442's recent admission a Comprehensive Minimum Data Set (MDS) and a Comprehensive Care Plan have not been completed. Resident #442's admission orders [REDACTED] Order Date: 2/13/2020 Admit to Hospice Services Resident #442's Baseline Care plan dated 2/13/20 was reviewed and there was no entry to show that the resident would be receiving hospice services. Unit Manager LPN (Licensed Practical Nurse) #7 was asked if she saw any entry on Resident #442 Baseline Care Plan indicating the resident was receiving hospice services. LPN #7 stated, No I don't, we should have added that in for her. The facility policy titled Care Planning dated 7/29/19 was reviewed and is documented in part, as follows: Policy: A Baseline care plan to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. Procedure: b.) The baseline care plan will form the foundation of the comprehensive care plan and be incorporated as the comprehensive care plan is developed. On 2/20/20 at 2:45 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. The Director of Nursing stated, I would have most definitely expected that hospice services be on her baseline care plan because it need to be person-centered. Prior to exit no further information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to revise 5 (Resident #52, #175, #100, #122 and #165) comprehensive person-centered care plans of 59 residents in the survey sample. The findings included: 1. The facility staff failed to revise Resident #52's comprehensive person centered care plan to include a stage III right ankle pressure ulcer. Resident #52 was originally admitted to the facility on [DATE]. Current [DIAGNOSES REDACTED]. Resident #52's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date of 11/21/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment skills for daily decision-making. During the review of Resident #52's current Physician order [REDACTED]. Review of Resident #52's person centered care plan did not include a Stage III pressure ulcer to the right ankle. A briefing was held with the Director of Nursing (DON) and Cooperate Nurse on 02/21/20 at approximately 4:00 p.m. The DON stated, Resident #52's wound to his right lateral ankle should have been care planned. Definitions: -Stage 3 pressure ulcer is full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not expose(http://www.npuap. org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). 2. The facility staff failed to revise Resident #175's comprehensive person centered care plan to include the discontinuation use of an indwelling Foley catheter. Resident #175 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #175's Minimum Data Set (MDS-an assessment protocol), a quarterly assessment with an Assessment Reference Date of 05/29/19 coded Resident #175 with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no impaired cognitive skills for daily decision-making. Review of Resident #175's person centered care plan had a problem which read: Resident #175 requires use of indwelling catheter. The goal read: will not demonstrate adverse outcome from use of indwelling catheter. Some of the interventions included: provide catheter care per order/facility policy, clean around catheter with soap and water and keep tubing below level of bladder and free of kinks or twists. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the review of Resident #175's current Physician order [REDACTED]. Review of facility's documentation included the following order: Indwelling Foley catheter discontinued on 07/19/19. A briefing was held with the Director of Nursing (DON) and Cooperate Nurse on 02/21/20 at approximately 4:00 p.m. The DON stated, Resident #175's care plan should have been revised on the date the Resident #175's Foley catheter was discontinued. Definitions: -Indwelling Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a 4.html). 3. The facility staff failed to revise Resident #100's person-centered care plan for the management of the medical [DIAGNOSES REDACTED]. Resident #100 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The current MDS (Minimum Data Set) a quarterly with an Assessment Reference Date of 12/31/19 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. Section I. Active [DIAGNOSES REDACTED]. The resident also coded as receiving oxygen. On 2/18/20 at 3:28 p.m., the resident was observed laying in bed with oxygen infusing at 2 liters per minute via nasal cannula. The tubing was dated as last changed on 2/17/20. On 2/19/20 at 10:10 a.m., 2/20/20 at 11:30 a.m., and on 2/21/20 at 1:51 p.m., the resident was observed in bed with oxygen in use via nasal cannula at 2 liters. The physician order [REDACTED]. Review of the Comprehensive Care Plan dated 11/28/18-Present failed to evidence it was revised with measurable objectives, timeframe's and interventions to meet the resident's medical needs for the management of the resident's respiratory condition to include oxygen therapy as ordered. The above findings was shared with the Administrator and the Director of Nursing (DON) during the pre-exit meeting conducted on 2/21/20. The DON was asked if Resident #100's person-centered comprehensive care plan should have been revised to include the management of [MEDICAL CONDITION] and use of oxygen, she stated, Yes. 4. The facility staff failed to revise Resident #122's person-centered care plan for the management of the medical [DIAGNOSES REDACTED]. Resident #122 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The current MDS (Minimum Data Set) a significant change with an Assessment Reference Date of 1/31/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. Section I. Active [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the person-centered plan of care dated 11/7/19-Present failed to evidence it was revised with measurable objectives, timeframe's and interventions to meet the resident's medical needs for the management of the active [DIAGNOSES REDACTED]. The above findings was shared with the Administrator and the Director of Nursing (DON) during the pre-exit meeting conducted on 2/21/20. The DON was asked if Resident #122's person-centered comprehensive care plan should have been revised to include the management of [MEDICAL CONDITION] disorder to include interventions she stated, Yes. 5. Resident #165 was originally admitted to the facility 1/20/20 and readmitted [DATE] after an acute care hospital stay. The current [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/27/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15; this indicated Resident #165's cognitive abilities for daily decision making were intact. In section G (Physical functioning) the resident was coded as requiring total care of two people with bathing, extensive assistance of two people with transfers and toileting, extensive assistance of one person with bed mobility, locomotion, dressing, and personal hygiene, and limited assistance of one person with eating. In section H0100 was coded no appliances in use and section H0300 was coded the resident was always incontinent. Resident #165 was observed during the initial tour 2/18/20, at approximately 1:40 p.m. seated across from the nurse's station in the corridor. The resident stated she had just had a birthday and was grateful to still be alive. A urinary catheter tubing was observed near the left leg draining light yellow urine. On 2/19/20 at approximately 11:5 a.m., an interview was conducted with certified nursing assistant (CNA) #7, who stated the resident didn't have a catheter prior to going to the hospital but upon return to the facility the catheter was in. On 2/20/19 at approximately 11:15 a.m., the resident was observed in bed receiving morning care. The indwelling catheter was anchored to the left thigh and continued to drain light yellow urine. On 2/20/20 at approximately 2:15 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 stated Resident #165 was diagnosed with [REDACTED]. LPN #2 further stated Resident #165 had been back in the facility about two weeks. LPN #2 reviewed Resident #165's current care plan which read active: the problem stated the resident has urinary incontinence. The goal read: assure adequate hygiene and clothing change and room odor free through the next review. An intervention read; check for incontinence, change if wet or soiled. Clean skin with a mild soap and water, dry skin and apply a moisture barrier. Note and report alterations in skin integrity. LPN #2 stated the MDS Coordinators, Unit Managers and the Clinical Coordinators are responsible for updating care plans and this one was not updated to include the indwelling catheter related to [MEDICAL CONDITION]. On 2/21/20, at approximately 1:15 p.m., the above findings were shared with the Administrator and Director of Nursing. The Director of Nursing stated the care plan should have reflected the residents current urinary status.

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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** Based on observation, staff interview, facility document review, and clinical record review; it was determined that facility staff failed to provide treatment and services to promote the healing of a pressure ulcer for two of 59 residents in the survey sample, Resident #189 and Resident #77. 1. For Resident #189, facility staff failed to thoroughly assess a healing stage 3 pressure ulcer* to her second right toe upon admission to the facility; and, failed to provide treatment in a timely manner. 2. For Resident #77, facility staff failed to apply physician ordered heel boots for the treatment and prevention of pressure ulcers. The findings included: 1. Resident #189 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #189's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 2/1/2020. Resident #189 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #189 was coded in Section N (Skin Conditions) as having a stage three wound and unstageable** wound that were both present on admission. Review of Resident #189's hospital discharge instructions dated 1/25/20 documented the following wound care orders: Post -Discharge Instructions: Wound Care Daily, Comments: Cleanse wound with normal saline (NS) flush and gauze. Irrigate until NS runs clear. Dress with [MEDICATION NAME] Calcium alginate dressing cut to cover wound bed, then 2x2 gauze (dressing), and 2 (inch) rolled gauze to secure. Wound Location: Right lateral foot. There were no other wounds addressed on the hospital discharge instructions. Review of Resident #189's admission skin assessment dated [DATE] documented the following: Skin Integrity: Specify details of skin conditions in Comments section below .Other was documented for skin area identified as R2 which indicated the right toe had some type of skin abnormality or condition. The following was documented under the Comments section: [MEDICAL TREATMENT] port left chest, Pace maker right chest. Resident feet with bunions bilaterally. Resident abdomen busied from the sides all the way around to the other side. There was no information documenting what was located to Resident #189's right toe. There was no assessment documented for Resident #189's right lateral foot wound. Review of Resident #189's admission note dated 1/25/20 documented in part, the following: Skin assessment completed. Sacrum blanchable red area, skin intact . There was still no information documenting what was located to Resident #189's right toe. There was no assessment documented for Resident #189's right lateral foot wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #189's January 2020 POS (physician order [REDACTED]. Irrigate until normal saline runs clear. Dress with [MEDICATION NAME] calcium alginate dressing cut to cover wound bed, then 2 x 2 gauze to secure. Further review of Resident #189's clinical record revealed that wound assessments were not completed until 1/27/20 (two days later) on the right lateral foot wound and the right second toe wound. The following was documented for the right second toe wound: admitted with healing stage three to right second toe hammer toe. Area originally presented as pressure from haertoe (sic) shape of toe that rubbed on foot, patient has a history of goat (sic) to the toe joint. Wound bed has 100 % (percent) bright red beefy granulation, peri wound intact ans (sic) blanchable with [DIAGNOSES REDACTED] and [MEDICAL CONDITION] R/T (related to) gout. Surrounding point is tender R/T gout diagnosis. Denies pain to wound bed. Provider assessed wound . Tx (treatment) and interventions put in place. RP (responsible party) aware of pressure ulcer .Wound Stage 3 Full thickness, Length (cm) (centimeters) 1.00 x Width (cm) 1.00 x (Depth) 0.3. Further review of Resident #189's clinical record revealed that a treatment was not put into place for Resident #189's right second toe until 1/31/20 (six days after admission). The following treatment was put into place: Healing stage 3 pressure ulcer to Right 2nd toe: Apply non sting prep and cover with small bordered foam. Further review of Resident #189's wound assessment revealed that her second right toe wound had improved in size. The following was documented on 2/13/20: Wound Stage 3 Full thickness, Length (cm) (centimeters) 0.40 cm x Width (cm) 0.30 x (Depth) less than 0.1. Resident #189 was discharged home on[DATE] (in the middle of survey). Her wound could not be viewed by this writer. The following discharge wound care note documented in part, the following: 2/19/20 Patient requested DSG (dressing) to R foot and R 2nd toe be changed this AM R/T (related to) patient being discharged today after lunch. (tx (treatment) normally evening shift). Wound care done per order. Patient educated on wound care. Patient and husband will be doing wound care @(at) home .Healing Stage 3 to Right second toe continues to show signs of improvement, area is smaller in size .Peri wounds has [DIAGNOSES REDACTED] and [MEDICAL CONDITION] r/t to shape of toe (hammertoe with H/O (history) of gout in toe . On 2/20/20 at 11:33 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, a nurse on the unit. When asked the process when a resident is admitted to the facility from the hospital with a wound, LPN #1 stated that with any new admission she would conduct a full head to toe assessment and document any skin areas with a description of the area. LPN #1 stated that she was not allowed to stage wounds; only the clinical managers were allowed to stage. LPN #1 also stated that she would apply the wound treatment that was specified on the hospital discharge orders. When asked the process if a resident had a wound that was not reflected on the hospital discharge instructions, LPN #1 stated that she would call the clinical manager to assess the wound to determine the appropriate treatment. When asked if it was ever okay to leave a wound without a treatment for [REDACTED].#1 stated that it was not okay. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/20 at 11:57 a.m., an interview was conducted with LPN # 3, the clinical manager. When asked the process if a resident was admitted to the facility with a wound, LPN #3 stated that the receiving nurse would conduct a head to toe assessment and document the areas. LPN #3 stated that the floor nurses were not allowed to stage wounds so the following day or if the clinical managers were present during the admission; they would go in to assess the wound and document measurements, stage etc. LPN #3 stated that floor nurses were educated on the difference between partial thickness and full thickness loss of pressure ulcer. LPN #3 stated that if the resident did not come into the facility with orders for wounds, she would expect the nurses to implement standing orders based on the type of thickness loss observed. LPN #3 stated that she would also expect the nurses to implement any treatments orders specified on the hospital discharge instructions. LPN #3 stated that she would have to find out more information regarding Resident #189's wound to her right second toe. On 2/20/20 at 1:59 p.m., an interview was conducted with LPN #2, the clinical coordinator who assessed Resident #189's wounds on 1/27/20. LPN #2 stated that Resident #189's wound to her second right toe was not a true stage 3, that it was a healing stage three. LPN #2 stated that the admission nurse probably missed the wound to Resident #189's right toe because on the surface the wound appeared to be a reddened area that was blanchable. LPN #2 stated that during her assessment on 1/27/20 she opened the toe and found a small open area. LPN #2 stated that the wound seemed to be doing well being left open to air, so she decided to leave it opened to air until 1/31/20 when Resident #189 started wearing shoes during her therapy sessions. LPN #2 stated that she was afraid the shoes would start rubbing on her toe and then decided to implement skin prep with a foam border dressing. When asked how she knew the wound was doing better if there was no prior skin assessment; no assessment done upon admission; LPN #2 stated that she had a discussion with the resident and her husband who stated that the wound to her right second toe was a chronic wound that used to be treated with [MEDICATION NAME] by her outside podiatrist. LPN #2 stated that [MEDICATION NAME] dressings were typically used to treat stage three pressure ulcers. LPN #2 also stated that she could also tell by her assessment that the wound was a healing stage three. LPN #2 stated that the hospital did not put an order in place for her toe wound and stated that she believed they were leaving it open to air. LPN #2 stated that she did expect the admission nurses to conduct thorough skin assessments; providing a description of the area and documenting measurements. LPN #2 also stated that if an order was not on the hospital discharge instructions for a skin area/pressure etc, she would expect the nurses to clarify with the physician or use their standing orders until assessed by the clinical managers. LPN #2 stated that the clinical managers will assess any wound if they are present at the time of admission or the following day. LPN #2 stated that if the resident arrived on a Saturday, she would assess the wound on the following Monday. When asked if she had to verify orders with the physician prior to implementing a treatment for [REDACTED]. When asked where the order was to leave the second right toe open to air after her assessment on 1/27/20, LPN #2 that she did not write an order but should have wrote an order as well as document the treatment in a nursing note. On 2/21/20 at 4:38 p.m., ASM (administrative staff member) #2, the Director of Nursing and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. The facility standing orders for pressure ulcers were not provided prior to exit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Skin Integrity and Prevention Care documents in part, the following: Initial and Weekly observations of all skin integrity issues will be completed on the Wound Care Assessment log include: a. Date of original onset b. Location of ulcer (be consistent in use of your terminology) after etiology determined d. Pain (presence of including intensity/frequency OR absence of) e. Size of wound (width, length, and depth - in centimeters) f. wound bed characteristics- tunneling, undermining, slough, eschar/necrotic tissue, type and amount of drainage. g. Peri-wound characteristics - intact, macerated, rolled edges, redness, induration (hardness) h. Provider, dietary and responsible party notification will be made with all progress or decline in ulcer that requires change of treatment order. 9. Treatment plans for prevention and/or treatment of [REDACTED]. The clinical record will contain documentation of the treatment provided. The following information was obtained from National Pressure Ulcer Advisory Panel website at http://www. npuap.org/pr2.htm. Pressure Ulcer* A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron ' s Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. *Stage three pressure ulcer-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable. **Unstagebable pressure ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without [DIAGNOSES REDACTED] or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed. [MEDICATION NAME] dressing- Medical grade honey based dressing used for the treatment of [REDACTED]. This information was obtained from https://www.integralife.com/[MEDICATION NAME]-wound-burn-dressing-us/product/wound-reconstruction-care-outpatient-clinic-private-office-prepare-[MEDICATION NAME]-wound-burn-dressing-us. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #77 was admitted to the facility on [DATE], discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #77's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/14/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #77 as requiring extensive assistance of 1 for bed mobility, transfer, dressing, eating, toilet use and personal hygiene and total dependence of 2 for bathing. On 02/18/2020 at 1:38 p.m. observed Resident #77 sitting up in dining room in geri lounger chair with heel boots on both feet. Per the nurse, Resident #77 has a Stage 3 pressure ulcer on her right heel. On 02/19/2020 at 10:21 a.m., observed Resident #77 sitting up in geri lounger chair. Resident #77 did not have on her heel boots. On 02/20/2020 at 9:00 a.m., observed Resident #77 sitting up in hall in a geri lounger chair with heel boots on both feet. On 02/20/2020 at 9:14 a.m., observed Licensed Practical Nurse (LPN) #11 perform care on Resident #77's pressure ulcer on the right heel. LPN #3 assisted LPN #11 as needed. LPN #11 performed treatments as ordered and performed hand hygiene as appropriate. Resident #77's pressure ulcer on her right heel was observed and noted to have depth with white slough and pink granulating tissue at the edges. On 02/20/2020 at approximately 10:20 a.m., an interview was conducted with LPN #11 and requested that she review Wound Assessments with the Surveyor. Review of Wound Assessments revealed the following: Assessment Date: 12/31/2019 Date Wound Identified: 12/31/2019 Source of Wound: Facility Acquired. Wound Location: Posterior Feet. Wound Type: Pressure. Wound Size: Length (cm) 1.50, Width (cm) 1.50, Depth (cm) 0.00 Wound Note: Area assessed to Right Posterior heel as DTI (Deep Tissue Injury). Area measures 1.5 x 1.5 and is 100% dark purple/dark red and non-blanchable. Area is intact, peri wound intact and blanchable. Provider made aware to assess and RP (Responsible Party) aware of area. New tx (Treatment) ordered for [MEDICATION NAME] and foam dressing. New order for heel boots put in place, and air mattress currently in place prior to DTI development. CP (Care Plan) updated. Will continue to monitor. On 02/20/2020 at approximately 11:00 a.m., review of Resident #77's clinical record revealed the following: Review of December 2019 Physician order [REDACTED]. Order for Apply skin prep Notes: Observe bilateral heels and apply skin prep every shift for 7 days for prevention of pressure injury. Order Date: 12/01/2019. Order for Air Mattress Order Date: 12/03/2019. Order for Ensure [MEDICATION NAME] 1 container liquid two times daily. Order Date: 12/17/2019. Order for Heel Boots Notes: While in bed and up in wheelchair for pressure reduction. Check for proper placement q (every) shift. Order Date: 12/31/2019. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens at Warwick Forest	1000 Old Denbeigh Boulevard Newport News, VA 23602

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order for Apply skin prep BID (Twice a day) to reddened area Two Times Daily starting 12/31/2019. Notes: Wound location right heel. Order for Multivitamin with minerals tablet 1 tablet every day. Order Date: 01/03/2020 Start Date: 01/05/2020. Order for Pro-Stat AWC oral liquid every day Order Date: 01/03/2020. On 02/21/2020 received copy of OSM (Other Staff Member) #14, Nurse Practitioner, Notes with a Encounter Date of 01/03/2020. Review of notes for Resident #77 revealed the following: Patient has developed a deep tissue injury to the right heel. Today on examination, the wound measures 1.5 cm x 1.6 cm. Review of notes in Musculoskeletal and Injuries section revealed the following: Interventions to prevent wound deterioration include: Air mattress, turning and repositioning patient every 2 hours by nursing staff, . On 02/21/2020 Resident #77's care plan was reviewed and revealed the following interventions: Air mattress applied after admission, Effective Date 12/31/2019; Encourage resident to re-position or provide assistance with turning and repositioning as needed, Effective Date 12/31/2019; The Administrator, Director of Nursing and Senior Director was informed of the finding on 02/21/2020 at approximately 5:30 p.m. The facility did not present any further information about the finding. The facility policy titled - Skin Integrity Prevention and Care - Focus on Pressure Ulcers Purpose: The nursing facility has a commitment to provide care and services for residents with the intent a resident does not develop pressure ulcers unless clinically unavoidable. The facility is also committed to identify other skin integrity issues and provide treatment for [REDACTED]. Promote the prevention of pressure ulcer development Promote the healing of all skin integrity issues that are present (including prevention of infection to the extent possible); and Assist the provider in investigation of etiology of the skin concern to provide the appropriate treatment and plan of care.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, family interview, clinical record review and facility document review the facility staff failed to prevent an avoidable fall for 1 of 59 residents in the survey sample, Resident #121. During the provision of care by staff, the resident fell off the bed and sustained left hip and left femur fractures. Following the fall, the facility staff did a root cause analysis and implemented a plan of correction with a completion date of 1/15/2020. No other falls during provision of care was identified after the completion date. The deficiency is cited as a level 3 isolated, past non-compliance. The findings included: Resident #121 was admitted to the facility on [DATE] with a readmission date of [DATE] following a hospitalization for surgical intervention to the left hip and proximal femur fractures resulting from a fall from the bed on 12/25/19 at the facility. The resident's other [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) prior to the fall was a quarterly with an Assessment Reference Date of 12/11/19. The resident was coded as scoring an 11 out of a possible 15 on the Brief Interview for Mental Status indicating the resident had moderately impaired daily decision making skills. The resident was dependent on two staff for transfers, dependent on one staff for bathing, and extensive assistance of one staff for bed mobility, dressing, toileting and personal hygiene. The resident was frequently incontinent of bladder and always incontinent of bowels. The physician orders dated 7/24/17 included an air mattress with perimeter cover for pressure relief, check function and inflation every shift. The person-centered plan of care effective date of 3/3/17-present identified the resident was at risk for falls and/or history of falls related to, unsteady gait, loss of balance, poor sitting balance/ poor trunk control, short-term memory loss, requires reminders to call for assistance, requires staff assistance for transfers, pain, impaired sensation, unstable/ fluctuating health conditions, diabetes, high blood pressure, use of narcotic [MEDICATION NAME] , incontinence and history of falls. The goal was that the resident will not experience significant injury (i.e., requiring ER visit or hospitalization) through next review. During each of the survey days 2/18/20, 2/19/20, 2/20/20 and 2/21/20 the resident was observed in bed on a bariatric low air loss mattress. There was no defined perimeter mattress in place; there was no physician's order after readmission for a perimeter cover. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the clinical record and facility event report evidenced the resident had a witnessed fall from the bed during ADL (activities of daily living) care on 12/25/19. As a result of the fall the resident sustained [REDACTED]. The resident was transferred to the emergency room for evaluation and admitted . The clinical notes by Licensed Practical Nurse (LPN) #9 dated 12/25/19 read in part: Resident fell out of bed @11:15. CNA (certified nursing assistant) reported to nurse while turning the resident the resident slid to the floor. Left leg in pain 10/10 (intensity of pain 1-10, 10 being the worst) and has 4 abrasions below the L (left) knee and 1 abrasion below the R (right) knee . The facility incident report also documented, Resident fell out of bed @11:15. CNA reported to nurse while turning the resident the resident slid to the floor. CNA#2 who was providing care at the time of the fall was interviewed on 2/21/20 at 12:30 p.m. CNA#2 stated that she was giving the resident a bed bath that morning, she had completed the top part of the resident's body and asked the resident to turn on her left side. She stated after the resident was turned to her side she completed washing her back and rolled the chux pad under the resident's bottom to change it, at this time the resident started scooting her bottom towards the edge of the bed to see something out the window. The resident then slid off the bed feet first. Immediately after the fall the resident began hollering in pain. When asked if the resident was readmitted back to the same room and same bed after hospitalization she stated, Yes. On 2/21/20 at 1:12 p.m., the daughter of the resident was interviewed. She stated she received a phone call from LPN #9 informing her of the fall. She was told that, When the aide (CNA) turned her she was too close to the edge. The hospital discharge summary documentation dated 1/1/20 indicated the resident had a fall while being given a bath per the daughter. The patient had been non-ambulatory for years and was bed-bound. The CT scan showed intramedullary [MEDICAL CONDITION] and proximal femur fracture. The patient was seen in consultation by Orthopedics and underwent cephalomedullary nail replacement of the left hip. On 2/21/20 at 2:30 p.m., the durable medical equipment specialist was interviewed on site. He stated the defined perimeter mattress is an added safety feature to prevent falls from low air loss mattresses. He further stated that the contract with the facility specifically calls for all low air mattresses rented to the facility must have the added safety feature of a defined perimeter mattress. The specialist was asked if Resident # 121 was on a perimeter mattress, after pulling up the order in his system he stated, Yes, since 2017. The specialist was asked to go into the resident's room to ensure the low air loss mattress that the resident was on included the defined perimeter mattress cover. Several minutes later he reported to this inspector that the resident's low air loss mattress did not include the defined perimeter mattress cover. He stated he called his company and one was on it's way. Per the manufacture the Defined Perimeter Mattress Cover creates a raised rail, defined perimeter for enhanced fall prevention, without using patient restraints. The 10 deep static perimeters surround the length of the mattress. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/21/20 at 3:02 p.m., the above findings was shared with the Director of Nursing (DON). She stated she was not aware that the resident was not on the perimeter mattress as ordered. When asked what is the purpose of the perimeter mattress she stated, I would suppose an added protection from falls. When asked what the root cause of the fall, she stated, I believe at the time the resident got distracted, she was not paying attention to what she was doing .I think the perimeter mattress would have helped her. A root cause analysis and plan of correction was completed and included resident assessments and staff education. No additional falls during provision of care was identified. The compliance completion date was documented as 1/15/20. The above findings was shared with the Administrator and the Director of Nursing (DON) during the pre-exit meeting conducted on 2/21/20. The facility was afforded ample time to present any additional information prior to exit. No additional information was presented. Past non-compliance.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medication pass observations, staff interviews, facility document review and clinical record review the facility staff failed to ensure they were free from a medication error rate of 5 % or greater. There were 28 observed medication opportunities with 2 errors (Resident #41 and #58), resulting in a 7.14% medication error rate. The findings include: 1. On 2/18/20 at 5:00 p.m., during the medication pass observation, for Resident #41, Licensed Practical Nurse (LPN) #11 administered 10 Units of *Humalog U-100 insulin (subcutaneously) before the evening meal. Resident #41 had physician's orders [REDACTED]. Resident #41's blood sugar reading was high at 253 mg/dL (milligrams/deciliter) prior to the administration of the insulin. After the observed error was brought to the attention of LPN #11, the LPN asked if the nursing facility needed different insulin syringes so you could see the lines more clearly. Additionally she said, Although I have been watched [AGE] years in a row by a State surveyor during a medication pass, it always makes me nervous. *Humalog U-100 HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus (https://www.rxlist.com/Humalog-drug.htm#indications). Resident #41 was admitted to the nursing facility on 3/1/19 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] coded the resident with a 14 out of a possible score of 15, which indicated the resident was fully intact in the skills for daily decision making. Resident #41 was coded with the [DIAGNOSES REDACTED]. The care plan dated 6/23/19 identified the resident had diabetes and to administered insulin and/or oral agent medication as ordered by the physician. On 2/21/20 at 4:30 p.m., the Director of Nursing (DON), along with two corporate nurses were made aware of the observed medication error on 2/18/20. The facility's policy and procedures titled Medication Administration Procedure dated revised on 2/20/20 indicated the nurse must ensure the six rights of medication safety that included right dose . The American Diabetes Association suggests the following targets for most nonpregnant adults with diabetes . Also, more or less stringent glycemic goals may be appropriate for each individual .Before a meal (preprandial plasma glucose): 80-130 mg/dL . www.diabetes.org. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #58 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #58's most recent MDS (minimum data set) assessment was and admission assessment with an ARD (assessment reference date) of 12/6/19. Resident #58 was coded as being intact in cognitive function scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. On 2/19/20 at 9:40 a.m., medication administration observation was conducted with LPN (Licensed Practical Nurse) #1. This writer observed LPN #1 prepare the following medication for Resident #58: [MEDICATION NAME] (1) 100 mg (milligram) tablet. At approximately 9:43 a.m., one (1) [MEDICATION NAME] tablet was administered to Resident #58. Review of Resident #58's February 2020 physician order [REDACTED]. This order was initiated on 12/18/2019. On 12/19/20 at 12:43 p.m., an interview was conducted with LPN #1. When asked how many capsules of [MEDICATION NAME] Resident #58 should receive, LPN #1 stated, I only give him one for my shift. LPN #1 stated that she was not sure what he received on the other shifts. LPN #1 then checked Resident #58's order and stated, Oh shoot. I only had the one. LPN #1 confirmed that his [MEDICATION NAME] order was for two capsules. LPN #1 stated that she did not follow the order. On 12/19/20 at 1:10 p.m., an interview was conducted with LPN #3, the clinical manager. When asked the process to prevent medication errors, LPN #3 stated that she would expect nursing staff to check the medication prior to administering with the order to ensure it is the right medication, dose, route etc. LPN #3 stated that nurses should double and triple check the medication with the order. On 2/21/20 at 4:38 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. Facility policy titled, Medication Administration Procedure documents in part, the following: Preparing medications: [REDACTED].Identify resident before you administer the medication. Identify your resident by checking the arm band and picture ID . (1) [MEDICATION NAME] used to relieve occasional constipation (irregularity) and generally produces bowel movement in 12 to 72 hours. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=7793fced-e8ee-44e2-b212-dd2a59a5f462.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility document review, it was determined the facility staff failed to ensure one of six medication carts were free from expired medications; the second medication cart on Monticello Unit. The findings included: On 2/21/20 at 11:49 a.m., inspection of the second medication cart on the Monticello Unit was conducted with LPN (Licensed Practical Nurse) #4. One bottle of Multivitamin One a Day gummies was found with an open date of 4/30/19. The expiration date documented 1/26/2020. When asked how often the medication carts were checked for expired items, LPN #4 stated that she checked the cart whenever she worked. When asked if the multivitamins were expired, LPN #4 checked the bottle and confirmed they had just hit the expiration date. LPN #4 then stated that the multivitamins belonged to (Name of Resident #3) and that she was taken off the multivitamin awhile back. LPN #4 then dumped the contents of the multivitamin bottle into the sharps container. Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident ##3's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 11/5/19. Resident #3 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #3's clinical record revealed that the multivitamin was not on the resident's February 2019 medication administration record. On 2/21/20 at 4:38 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. Facility policy titled, Medication Storage documents in part, the following: 10. Expired and discontinued medications are returned/destroyed in a timely manner .Medication refrigerator and medication/treatment carts are free of expired medications and biologicals