PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495147		C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/10/17 through 01/11/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 109 certified bed facility was 95 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 16) and 3 closed record reviews (Residents 17 through 19).	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth of the Statement of Deficiencies. This plan of Correction is prepared and / or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	2/8/2017
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225	1) Employee was suspended on 11/1/2016 upon receiving notification from Adult Protective Services (APS) regarding alleged verbal abuse towards Resident #2. On 11/7/2016, employee was terminated based on final investigation outcome. A Facility Reportable Incident (FRI) along with the five day follow up investigation was submitted to VDH for reporting purposes on resident #2 and #17. 2) The Administrator completed an audit of residents here during the year of 2016 to current. Any issues/ concerns identified or Adult Protective Services (APS) contacted either internally or externally on any in-house resident, will have a FRI along with the 5 day follow up investigation submitted as deemed appropriate.	

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JAN 27 2017
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glen Queen
TITLE: Executive Director
(X8) DATE: 1/27/17

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

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F 225 Continued From page 1

licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

F 225

3) In-service provided to current employees on the Abuse and Neglect Policy and procedure. All incidents reported regarding any form of abuse towards residents will have a Facility Reportable Incident (FRI) completed as well as a five day follow up report from the investigation from the facility Administrator and/ or designee.

4) On-going monitoring will be conducted through resident interviews and care planning meetings.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

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F 225	Continued From page 2	F 225		

corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to report allegations of abuse for two of 19 residents in the survey sample. Resident # 2 and Resident # 17.

1. The facility staff failed to report a verbal abuse allegation of a housekeeping staff member toward Resident #2 witnessed by two APS (Adult Protective Service) workers on 10/28/16 and failed to report the results of the investigation to the State Survey and Certification Agency within 5 working days of the incident.

2. The facility staff failed to report to the state agency an allegation of abuse/neglect toward Resident # 17 from two personal caregivers that he had at his private home.

The findings included:

Resident #2 was admitted to the facility on 12/22/15. Diagnoses for Resident #2 included but are not limited to dementia, depression, anemia (decreased red blood cells), and diabetes (abnormal blood sugar levels). Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/20/16 coded Resident #2 with no cognitive impairment.
In addition, the Minimum Data Set coded Resident #2 requiring no assistance only supervision from staff for Activities of Daily Living care (eating, dressing).

On 1/10/17, Resident #2's clinical record was reviewed. The reviewed revealed an APS referral

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F 225	Continued From page 3 concerning a witnessed act of verbal abuse from a staff member to Resident #2 on 10/28/16. The referral read, two Adult Protective Service staff members witnessed facility staff state, "stop complaining" in a rude tone to Resident #2. Also, noted Resident #2 does not remember the incident but stated that she would be upset if someone told her to stop complaining. Notice of this incident of verbal, mental abuse and investigation by APS was received in the State Office of Licensure and Certification on 12/06/16. On 1/11/17 at approximately 10:00 a.m., the Administrator was interviewed. The Administrator explained that the incident of verbal abuse had occurred on 10/28/16 at approximately 11:35 a.m. per a notification letter and a visit from two APS workers to the facility on 11/1/16. Immediately following this notification on 11/1/16, the staff member involved was suspended pending an internal investigation. As a result of the investigation and in collaboration with APS, the staff member was terminated on 11/7/16 for verbal abuse of Resident #2. A facility documentation review was conducted on 1/11/17. The facility staff member in question was hired on 7/14/15 and a criminal background check was processed on 7/6/15. This staff member was hirable with no barrier crimes on the record. In addition, the staff member signed two statements that she had read and received the Abuse/Neglect Policy dated 7/10/15 and 9/6/16. On 1/11/17 at approximately 12:20 p.m., the Administrator stated, "I should have reported this [abuse allegation and investigation] to your office [Virginia Department of Health: Office of Licensure and Certification] but I thought APS	F 225		

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F 225 Continued From page 4

F 225

would report it...I should have reported on behalf of the facility." The Administrator also agreed that the follow-up results from the investigation should have been reported to the State agency.

The Abuse, Neglect, Exploitation and Injuries of Unknown Origin Policy with a revision date of 09/16 documented the following: "All alleged violations involving abuse, neglect, or exploitation, including injuries of unknown source, misappropriation of resident property, or taking photographs or making recordings in violation of this policy are to be reported immediately to ...always report to State Survey and Certification Agency and follow Federal guidelines for reporting." Also, documented in this policy was the following statement: "The results of all investigations must be reported within 5 working days to the Administrator and other officials in accordance with local, state and federal law (including the state survey and certification agency)."

The facility administration was informed of the findings during a briefing on 1/11/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.

2. The facility staff failed to report an allegation of abuse/neglect to the state agency for Resident # 17 regarding two personal caregivers the resident had at his personal home residence.

Resident # 17 was admitted to the facility originally on 06/24/16 and discharged on

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F 225	Continued From page 5 09/20/16. Diagnoses for Resident # 17 included, but were not limited to: atrial fibrillation, quadriplegia, neurogenic bladder, history of UTI's (urinary tract infections), anxiety disorder, and stage 4 pressure ulcer. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/06/16, which assessed the resident as having short and long term memory impairment, with severe impairment in daily decision making skills. The resident was also assessed as requiring total assistance from at least one person for all ADL's (activities of daily living). During a complaint investigation on 01/11/17, Resident # 17's clinical record was reviewed. A SW (social worker) progress note dated 07/06/16 documented, "...met with resident...much better spirits and lucid today...talked about upcoming discharge from facility. When asked how he felt about leaving he stated "Honestly I don't feel ok" When asked why he stated "My 2 caregivers [name of caregiver] and [name of caregiver] are the worst...doesn't do anything- he gets me in and out of bed and that's it. [name of other caregiver] cooks and that's it...I'm paying them $9/hr to do nothing and they live with me...Reassured resident that if he didn't feel safe discharging next week that we could definitely postpone discharge. Resident in agreement and thankful for conversation...notified resident's RP [responsible party]...also called [name] with APS [adult protective services...administrator made aware of situation..."	F 225		

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F 225	Continued From page 6 On 01/11/17 at approximately 12:50 p.m., the SW was interviewed regarding the above information and was asked if she was aware of the resident having his credit cards used without his permission by the 2 personal care staff at his home. The SW did not recall the later, but stated that she did report to APS and the administrator what the resident had said about his 2 caregivers in his home. At 2:00 p.m., the SW presented a letter from APS dated 08/25/16. The letter in summary was notifying the facility that the investigation was complete, but did not have any specific information or what the outcome of the investigation determined. The SW stated that she did not about the resident's credit cards until after APS got involved and she had heard about it. The SW was asked if this was something that she would report to the state agency. The SW stated that she did not know, but would find out. At approximately 2:45 p.m., the SW and administrator were again interviewed. the administrator stated that they (the facility) did not think this was something they needed to report to the state agency since this was not an event that was taking place in the facility. the administrator stated that it was reported to APS and the local authorities were involved, as well. No further information or documentation was presented prior to the exit conference on 01/11/17 at 4:15 p.m.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC	F 226		

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F 226	Continued From page 7 POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95. 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow the abuse policy and procedures for reporting an abuse allegation and the results	F 226	1) Employee was suspended on 11/1/2016 upon receiving notification from Adult Protective Services (APS) regarding alleged verbal abuse towards Resident #2. On 11/7/2016, employee was terminated based on final investigation outcome. A Facility Reportable Incident (FRI) along with the five day follow up investigation was submitted to VDH for reporting purposes on resident #2 and #17. 2) The Administrator completed an audit of residents here during the year of 2016 to current. Any issues/ concerns identified or Adult Protective Services (APS) contacted either internally or externally on any in-house resident, will have a FRI along with the 5 day follow up investigation submitted as deemed appropriate. 3) In-service provided to current employees on the Abuse and Neglect Policy and procedure. All incidents reported regarding any form of abuse towards residents will have a Facility Reportable Incident (FRI) completed as well as a five day follow up report from the investigation from the facility Administrator and/ or designee. 4) On-going monitoring will be conducted through resident interviews and care planning meetings.	2/8/2017

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F 226	Continued From page 8 of the investigation to the State agency for 2 of 19 residents. (Resident #2 and Resident # 17). 1. The facility staff failed to follow the Abuse, Neglect, Exploitation and Injuries of Unknown Origin Policy with a revision date of 09/16 to report a verbal abuse allegation of a housekeeping staff member toward Resident #2. Also, the facility staff failed to follow the policy to report the results of the investigation to the State Survey and Certification Agency within 5 working days of the incident. 2. The facility staff failed to implement written policies and procedures for abuse/neglect reporting for Resident # 17: Resident reported to the facility SW (social worker) that his two personal caregivers at his home residence were not taking care of him appropriately, this information was not reported to the state agency. The findings included: Resident #2 was admitted to the facility on 12/22/15. Diagnoses for Resident #2 included but are not limited to dementia, depression, anemia (decreased red blood cells), and diabetes (abnormal blood sugar levels). Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/20/16 coded Resident #2 with no cognitive impairment. In addition, the Minimum Data Set coded Resident #2 requiring no assistance only supervision from staff for Activities of Daily Living care (eating, dressing). On 1/10/17, Resident #2's clinical record was reviewed. The reviewed revealed an APS referral concerning a witnessed act of verbal abuse from	F 226	The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

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F 226	Continued From page 9 a staff member to Resident #2 on 10/28/16. The referral read, two Adult Protective Service staff members witnessed facility staff state, "stop complaining" in a rude tone to Resident #2. Also, noted Resident #2 does not remember the incident but stated that she would be upset if someone told her to stop complaining. Notice of this incident of verbal, mental abuse and investigation by APS was received in the State Office of Licensure and Certification on 12/06/16. On 1/11/17 at approximately 10:00 a.m., the Administrator was interviewed. The Administrator explained that the incident of verbal abuse had occurred on 10/28/16 at approximately 11:35 a.m. per a notification letter and a visit from two APS workers to the facility on 11/1/16. Immediately following this notification on 11/1/16, the staff member involved was suspended pending an internal investigation. As a result of the investigation and in collaboration with APS, the staff member was terminated on 11/7/16 for verbal abuse of Resident #2. A facility documentation review was conducted on 1/11/17. The facility staff member in question was hired on 7/14/15 and a criminal background check was processed on 7/6/15. This staff member was hirable with no barrier crimes on the record. In addition, the staff member signed two statements that she had read and received the Abuse/Neglect Policy dated 7/10/15 and 9/6/16. On 1/11/17 at approximately 12:20 p.m., the Administrator stated, "I should have reported this [abuse allegation and investigation] to your office [Virginia Department of Health: Office of Licensure and Certification] but I thought APS would report it...I should have reported on behalf	F 226		

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F 226	Continued From page 10 of the facility." The Administrator also agreed that the follow-up results from the investigation should have been reported to the State agency. The Abuse, Neglect, Exploitation and Injuries of Unknown Origin Policy with a revision date of 09/16 documented the following: "All alleged violations involving abuse, neglect, or exploitation, including injuries of unknown source, misappropriation of resident property, or taking photographs or making recordings in violation of this policy are to be reported immediately to ...always report to State Survey and Certification Agency and follow Federal guidelines for reporting." Also, documented in this policy was the following statement: "The results of all investigations must be reported within 5 working days to the Administrator and other officials in accordance with local, state and federal law (including the state survey and certification agency)." The facility administration was informed of the findings during a briefing on 1/11/17 at approximately 2:30 p.m. The facility did not present any further information about the findings. 2. The facility staff failed to report an allegation of abuse/neglect to the state agency for Resident # 17 regarding two personal caregivers the resident had at his personal home residence. Resident # 17 was admitted to the facility originally on 06/24/16 and discharged on 09/20/16. Diagnoses for Resident # 17 included, but were not limited to: atrial fibrillation,	F 226		

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F 226	Continued From page 11	F 226		

quadriplegia, neurogenic bladder, history of UTI's (urinary tract infections), anxiety disorder, and stage 4 pressure ulcer.

The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/06/16, which assessed the resident as having short and long term memory impairment, with severe impairment in daily decision making skills. The resident was also assessed as requiring total assistance from at least one person for all ADL's (activities of daily living).

During a complaint investigation on 01/11/17. Resident # 17's clinical record was reviewed.

A SW (social worker) progress note dated 07/08/16 documented, "...met with resident...much better spirits and lucid today...talked about upcoming discharge from facility. When asked how he felt about leaving he stated "Honestly I don't feel ok" When asked why he stated "My 2 caregivers [name of caregiver] and [name of caregiver] are the worst...doesn't do anything- he gets me in and out of bed and that's it. [name of other caregiver] cooks and that's it...I'm paying them $9/hr to do nothing and they live with me...Reassured resident that if he didn't feel safe discharging next week that we could definitely postpone discharge. Resident in agreement and thankful for conversation...notified resident's RP [responsible party]...also called [name] with APS [adult protective services...administrator made aware of situation..."

On 01/11/17 at approximately 12:50 p.m., the SW was interviewed regarding the above information

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495147		C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

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F 226 Continued From page 12

F 226

and was asked if she was aware of the resident having his credit cards used without his permission by the 2 personal care staff at his home. The SW did not recall the later, but stated that she did report to APS and the administrator what the resident had said about his 2 caregivers in his home.

At 2:00 p.m., the SW presented a letter from APS dated 08/25/16. The letter in summary was notifying the facility that the investigation was complete, but did not have any specific information or what the outcome of the investigation determined.

The SW stated that she did not about the resident's credit cards until after APS got involved and she had heard about it. The SW was asked if this was something that she would report to the state agency. The SW stated that she did not know, but would find out.

The facilities policy, "The Abuse, Neglect, Exploitation and Injuries of Unknown Origin Policy with a revision date of 09/16" documented the following: "All alleged violations involving abuse, neglect, or exploitation, including injuries of unknown source, misappropriation of resident property, or taking photographs or making recordings in violation of this policy are to be reported immediately to ...always report to State Survey and Certification Agency and follow Federal guidelines for reporting."

At approximately 2:45 p.m., the SW and administrator were again interviewed. the administrator stated that they (the facility) did not think this was something they needed to report to the state agency since this was not an event that

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495147		C 01/11/2017

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F 226	Continued From page 13 was taking place in the facility. the administrator stated that it was reported to APS and the local authorities were involved, as well. No further information or documentation was presented prior to the exit conference on 01/11/17 at 4:15 p.m.	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 279	1) Care plan on resident #1 was reviewed and updated to reflect current care for colostomy. Care plan on resident #4 was reviewed and updated to reflect current care for communication. 2) 100% audit of all current residents with colostomy care required was conducted by MDS Coordinators to ensure current care plan accuracy. No other issues identified. 100% audit of all current residents with communication deficits was conducted by MDS Coordinator or designee to ensure current care plan accuracy. No other issues identified. 3) In-service provided by Director of Clinical Reimbursement/ MDS and/ or designee regarding accurate assessments and revisions of care plans to all MDS coordinators and interdisciplinary team.	2/8/2017

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C
	495147		01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279 Continued From page 14

under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for two of 19 residents in the survey sample. Resident #1 had no care plan developed regarding care for a colostomy. Resident #4 had no care plan to address communication difficulties.

F 279

4) Weekly care plan audits for all residents with colostomy and will continue weekly for 6 weeks to ensure care plans remain accurate then randomly thereafter.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 15 The findings include:	F 279		

1. Resident #1 had no care plan developed regarding a colostomy.

Resident #1 was admitted to the facility on 6/10/16 with a re-admission on 12/8/16. Diagnoses for Resident #1 included pneumonia dysphagia, colon cancer, bladder cancer, COPD (chronic obstructive pulmonary disease), stroke and history of bowel resection with colostomy. The minimum data set (MDS) dated 12/9/16 assessed Resident #1 with severely impaired cognitive skills.

Resident #1's clinical record documented a physician's order dated 12/8/16 requiring the resident's colostomy bag to be checked and emptied each shift and replaced as needed. The resident's treatment record for January 2017 documented the colostomy bag was emptied each shift as ordered.

Resident #1's plan of care (revised 12/20/16) included no problems, goals and/or interventions regarding care for the resident's colostomy. The care plan listed the resident had "recent surgery for rectal cancer" but made no mention of the colostomy.

On 1/11/17 at 8:45 a.m. the licensed practical nurse (LPN #3) caring for Resident #1 was interviewed. LPN #3 stated the resident had a colostomy. Concerning the care plan, LPN #3 stated the MDS nurses were responsible for care plan development.

On 1/11/17 at 8:50 a.m. the unit manager (LPN #2) was interviewed about a care plan for

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495147		C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 16 Resident #1's colostomy. LPN #2 stated the MDS nurses were responsible for care plan development and the colostomy should be part of the resident's plan of care. On 1/11/17 at 8:55 a.m. the registered nurse MDS coordinator (RN #2) was interviewed about a plan of care regarding Resident #1's colostomy. After reviewing the care plan, RN #2 stated, "I don't see anything. He has a colostomy." RN #2 stated care for the colostomy should have been part of the care plan. The Lippincott Manual of Nursing Practice 10th edition on page 659 describes a colostomy as a "surgically created opening between the colon and the abdominal wall to allow fecal elimination..." This reference documents standards of care guidelines for patients with a colostomy to include monitoring the colostomy output each shift, periodically changing the pouch system to avoid leakage, protecting surrounding skin from fecal material and encouraging patient to verbalize feelings about body image changes related to the colostomy. (1) These findings were reviewed with the administrator and director of nursing during a meeting on 1/11/17 at 2:30 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. 2. Resident #4 did not have a comprehensive care plan to include communication.	F 279		

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
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F 279	Continued From page 17	F 279		

Resident #4 was admitted to the facility on 2/26/16 with a readmission on 10/3/16 with diagnoses including post traumatic stress disorder, dysphasia (speech impairment) secondary to stroke.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/11/16. Resident #4 was assessed as being cognitively intact.

On 1/10/17 at 2:30 p.m. Resident #4 conversed with a survey team member regarding some concerns. During the conversation Resident #4 verbalized that he becomes frustrated when talking with staff and staff does not understand due to speech impairment, resulting in Resident #4 talking louder and staff verbalizing (to Resident #4) that he is being rude.

Resident #4's electronic record was reviewed on 1/10/17 and evidenced, via most recent MDS dated 11/11/16, section "B" that Resident #4 had triggered for "Unclear speech" "usually understood- difficulty communicating some words [...]"

Review of the facilities "Roster/Sample Matrix" (CMS form 802) triggered Resident #4 for "communication." Section "V" of Resident #4's MDS did not trigger a care plan for communication.

On 1/11/17 at 8:00 a.m. the speech therapist's (other staff, OS #3 and #4) was interviewed concerning Resident #4's speech impairment. Both therapist verbalized Resident does not speak clear and can become frustrated at times

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495147		C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279 Continued From page 18 F 279

when talking with staff. OS #4 verbalized that speech therapy had been provided and instructed Resident #4 to speak loud as this helps him to pronounce words more clearly. OS #3 also provided documentation evidencing this information.

On 1/11/17 at 8:20 a.m. Resident #4's certified nursing assistant (CNA #4) was interviewed regarding communication. CNA #4 verbalized Resident #4 is hard to understand and if staff con't understand what he (Resident #4) said the first time he (Resident #4) gets upset and loud.

On 1/11/17 at 8:35 a.m. the above information was presented to the MDS coordinator (registered nurse, RN #2). RN #2 reviewed the most recent MDS and verbalized that she was aware of Resident #4 speech impairment and agreed that a care plan should be in place. RN #2 verbalized that the social worker is responsible for the MDS assessment under section "B."

On 1/11/17 at 8.45 a.m. the social worker (SW) was interviewed concerning Resident #4. The SW reviewed the information provided and verbalized that she (SW) was able to understand what Resident #4 was saying and felt that a care plan was not needed.

On 1/11/17 at 3:00 p.m. the above information was provided to the administrator and director of nursing during a meeting.

No other information was provided prior to exit conference on 1/11/17.

F 280 SS=D 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP F 280

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
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F 280	Continued From page 19	F 280		2/8/2017

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must–

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

1) Care plan on resident #5 was reviewed regarding the fall mat and wanderguard. It was clinically determined by the IDT Team that the fall mat and wanderguard were not needed and was removed from the residents care plan.

Care plan on resident #10 was reviewed and revised by the IDT Team with appropriate interventions for weight loss now included. Also, Speech consult was completed on 1/12/17 for resident #10.

2) 100% care plan audit was completed for all resident who have fall interventions to include fall mats and wander guards to confirm care plan accuracy. No additional changes were required for update.

100% audit was completed for all residents who trigger for weight loss to ensure appropriate interventions are in place and confirmed with physician promptly. No additional changes were required for update.

3) In-service training was provided by the Corporate Director of Clinical Reimbursement/ MDS regarding accurate assessments and revisions of care plans to all MDS coordinators and interdisciplinary team.

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495147		C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 20	F 280		

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

F 280

4) Weekly care plan audits for all residents with fall interventions, wanderguard and triggers for weight loss will continue weekly for 6 weeks to ensure care plans remain accurate then randomly thereafter.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495147		C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280 Continued From page 21

F 280

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for two of 19 residents in the survey sample, Resident #5 and #10.

1. Facility staff did not update Resident #5's CCP to remove placing floor mat when resident in bed and use of a Wanderguard.

2. Facility staff failed to review and revise Resident #10's CCP to include weight loss interventions.

Findings included:

1. Facility staff did not update Resident #5's CCP to remove placing floor mat when resident in bed and use of a Wanderguard.

Resident #5 was originally admitted to the facility on 10/29/15 and readmitted on 03/01/16 with diagnoses including, but not limited to: Dementia, Diabetes, Delusions, Paranoid Schizophrenia, Depression, Congestive Heart Failure, Hypertension and a history of falls.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/22/16. Resident #5 was assessed as moderately intact in her cognitive skills with a total cognitive score of 11 out of 15.

Resident #5's electronic medical record (EMR) was reviewed on 01/10/17 at approximately 2:15 p.m. The CCP for this resident included an

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
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F 280	Continued From page 22 intervention under fall care plan that stated, "...fall mat on floor at bedside when resident in bed...Date Initiated: 11/30/2015...Revision on: 11/30/2015..." Included in her behavior care plan was an intervention that stated, "...wander guard-(Name) will remove wander guard at times...Date Initiated: 01/10/2016 Created on: 01/10/2016..." Resident #5 was observed ambulating in the hallway with an aide on 01/10/17 at 2:25 p.m. No wander guard was in place. This resident was observed in bed at approximately 3:30 p.m. No fall mat was in place at the bedside. Resident #5 was observed in bed on 01/11/17 at 7:55 a.m. Again no fall mat was in place at the bedside. LPN #4 (licensed practical nurse) was interviewed on 01/11/17 at 8:20 a.m. regarding use of a fall mat with Resident #5 when in bed. LPN #4 stated, "No, it would be a trip hazard for her." The survey team met with the Administrator and DON (director of nursing) on 01/11/17 at approximately 3:00 p.m. The DON was interviewed regarding use of a fall mat and a wander guard for Resident #5. The DON stated, "She doesn't have a fall mat. That would be more of a fall hazard for her than a help. She hasn't fallen out of the bed in a long time. She does not have a wander guard in place." Regarding who updates care plans the DON stated, "MDS updates the care plans. We need to inservice and educate." No further information was received by the survey team prior to the exit conference on 01/11/17.	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495147		C 01/11/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23	F 280		

2. The facility staff failed to review and revise the CCP (comprehensive care plan) for Resident # 10 for weight loss interventions.

Resident # 10 had a significant weight loss of 9 lbs (pounds) in one month.

Findings include:

Resident # 10 was admitted to the facility on 09/23/97, with the most current readmission on 07/01/08. Diagnoses for Resident # 10 included, but were not limited to: moderate intellectual disability, anxiety disorder, DM (diabetes mellitus), dementia with behavioral disturbance, depression and dysphasia.

The most current quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 assessed the resident with a cognitive score of "0", indicating the resident was severely impaired cognitively in daily decision making skills. The resident was also assessed as requiring extensive to total assistance from staff for all ADL's (activities of daily living) except for eating, where the resident was assessed as independent with set up help only.

During clinical record review on 01/10/17 at approximately 1:30 p.m. Resident # 10's clinical record was reviewed. A dietary communication form dated 12/08/16 was reviewed. The form documented, "...weight seems to have dropped 9 lb from 11/1 [16] to 12/01 [16] Previously weight stable. Recommend: 1. reweigh 2. nutritional treat BID [twice daily] due to poor oral intake 3. ST [speech therapy] for most appropriate diet texture..." This form had a hand written entry that documented, "order entered speech made aware"

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
NAME OF PROVIDER OR SUPPLIER AVANTE AT WAYNESBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 ROSSER AVE WAYNESBORO, VA 22980	

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F 230	Continued From page 24 and was signed by the DON (director of nursing).	F 280		

Further review of the resident's clinical record revealed a progress note dated 12/03/16 and timed 5:04 p.m., which documented: "RD [registered dietitian] Weight note: value: 155 [lbs]...5.0 % change over 30 days (5.5%, 9.0)...Resident's wt [weight] appears to have dropped 9 lb from Nov 1 to Dec 1. Weight previously stable from 160-168 lb...recommend reweigh to rule out errors in measuring. Also recommend nutritional treat BID as her meal intake is poor. Recommend ST evaluation to ensure finger foods diet still appropriate...signature of RD."

No evidence of the resident being re-weighed could be located in the clinical record.

No evidence of ST consult or evaluation could be located in the clinical record.

The nutritional treat BID was initiated on 12/12/16, four days after the recommendation.

A progress note dated 12/15/16 and timed 2:11 p.m., documented: "RD [registered dietitian] Weight note: value: 156...Resident discussed...her weight decreased additional 2 lb from 12/9 to 12/12. Nutritional treat BID was just started 12/12...Unclear if previous RD recommendations re: ST evaluation has been done. If not, please have ST screen to ensure current diet appropriate...signature of temporary RD."

Resident # 10's current CCP (comprehensive care plan) was reviewed and documented. "Name of resident is at risk for weight loss without

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495147		C 01/11/2017

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F 280 Continued From page 25

F 280

proper po [by mouth] intake [06/11/15]...will consume at least 50%...to promote weight maintenance and optimal nutrition... [10/24/16]....adaptive equipment as ordered...encourage...to eat at meal time....no straws...provide diet as ordered...provide extra time...provide finger foods...provide thickened liquids..." Of the above listed interventions, the most recent revision was on 08/01/16 for the adaptive equipment- no new interventions implemented.

At approximately 2:00 p.m., the resident's meal percentages were reviewed for the month of January 2017. It was documented that the resident ate 0-25% for breakfast that morning and it was documented that the resident ate 26-50% for lunch that day. The remaining of the month January 1st through 10th, it was documented that the resident ate 0-25 % for 18 out of 30 meals and ate 26-50 % for 12 out of 30 meals.

At approximately 2:15 p.m., the DON stated that the ST evaluation for Resident # 10 had not been done and looked as if the "ball had dropped." The DON further stated that she could not find a re weigh for Resident # 10 until 12/15/16 (a week after the recommendation) and that she did not know why the supplement for Resident # 10 did not get implemented until four days after the recommendation. The DON was informed that the resident's CCP had not been updated to reflect any of the above information.

The DON and administrator were made aware of concerns regarding Resident # 10 and that the resident's CCP had not been updated with any interventions since 08/01/16, in a meeting with the survey team on 01/11/17 at approximately

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER: AVANTE AT WAYNESBORO		STREET ADDRESS, CITY, STATE, ZIP CODE: 1221 ROSSER AVE WAYNESBORO, VA 22980	

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F 280	Continued From page 26 3:30 p.m. No further information or documentation was presented prior to the exit conference on 01/11/17 at 4:15 p.m.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow a physician's order for one of 19 residents in the survey sample. Resident #1, with a physician's	F 309	1) Physician order for resident #1 was reviewed and clarified to include defined clinical parameters for physician notification. 2) 100% audit was completed on all residents with folly catheters. No other issues identified. 3) In-service instruction and training was initiated on 1/12/17 for licensed nurses regarding orders that require physician notification of a result outside the ordered parameter. 4) The DON or designee will review all future admissions with residents who have catheters for to assure compliance with ordered clinical parameters. Clinical team will continue to monitor the output of residents with folly catheters at least 5 times a week for 6 weeks and as then randomly thereafter. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	2/8/2017

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 309	Continued From page 27 order to alert the doctor of diminished urinary output, had three shifts of lower urine output with no notification to the physician.	F 309		

The findings include:

Resident #1 was admitted to the facility on 6/10/16 with a re-admission on 12/8/16. Diagnoses for Resident #1 included pneumonia, dysphagia, colon cancer, bladder cancer, COPD (chronic obstructive pulmonary disease), stroke and history of bowel resection with colostomy. The minimum data set (MDS) dated 12/9/16 assessed Resident #1 with severely impaired cognitive skills.

Resident #1's clinical record documented the resident had a prescribed Foley urinary catheter due to a history of bladder cancer. The record documented a physician's order dated 12/8/16 stating, "Record foley out put QS [each shift] Alert MD [physician] of any S/S [sign/symptoms] of infection or diminished output." (sic)

Resident #1's treatment record for 1/1/17 through 1/10/17 documented the resident's urinary output from the catheter each shift. Output by shift ranged from 100 to 450 cubic centimeters (cc's) with the exception of three shifts. The evening shift on 1/7/17 documented an output of 80 cc's, on 1/8/16 an output of 60 cc's and 1/9/17 an output of 80 cc's. The clinical record including nursing notes documented no interventions regarding the decreased output assessed on 1/7/17, 1/8/17 and 1/9/17. There was no notification to the physician or any further assessment regarding the lower than usual urine output amounts.

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 28 On 1/11/17 at 8:45 a.m. the licensed practical nurse (LPN #3) caring for Resident #1 was interviewed about the urine output amounts. LPN #3 stated the resident usually had from 150 to 200 cc's per shift and occasionally had outputs of 100 cc's per shift. Regarding the lower outputs of 60 and 80 cc's, LPN #3 stated those occurred on the evening shifts and she did not know if any notifications were done in response to the lower outputs. On 1/11/17 at 8:50 a.m. the unit manager (LPN #2) was interviewed about any notification regarding the lower urine outputs recorded on 1/7/17 through 1/9/17. LPN #2 stated any interventions regarding the lower urine amounts would be recorded in the nursing notes. LPN #2 stated there should have been communication to the physician about the lower amounts since there was a physician's order for an alert. On 1/11/17 at 10:05 a.m. the director of nursing (DON) was interviewed about any alert or notification to the physician regarding the resident's reduced urine output amounts. The DON stated she was not sure if the lower amounts were due to aides working over and recording the output at different times during the shift. The DON reviewed the record and presented no evidence of any interventions taken in response to the lower than usual urine output amounts for Resident #1. On 1/11/17 at 10:20 a.m. the DON stated she reviewed the activity of daily living records and the urine output amounts recorded for Resident #1 were the same as those listed on the treatment record. These findings were reviewed with the administrator and director of nursing during a	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

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	495147		C 01/11/2017

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F 309	Continued From page 29 meeting on 1/11/17 at 2:30 p.m.	F 309		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

(g) Assisted nutrition and hydration.
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, the facility staff failed to ensure acceptable parameters of nutritional status to prevent a significant weight loss for one of 19 residents in the survey sample. Resident # 10.

Resident # 10 had a significant weight loss of 9 lbs (pounds) in one month.

Findings include:

Resident # 10 was admitted to the facility on 09/23/97, with the most current readmission on 07/01/08. Diagnoses for Resident # 10 included,

2/8/2017

1) Resident #10 has was placed on weekly weights on 12/9/16 to monitor for any continued weight changed. Resident #10's weight remained stable for 4 weeks.

2) 100% audit was completed on all current residents' weights. No other issues/ concerns were identified, all current interventions in place.

3) Any resident who triggers for weight gain/ loss will be discussed during weekly weight meeting to ensure appropriate interventions are in place with timely follow up. If a weight loss or gain is noted, appropriate notification will be provided to the physician and RD.

4) On-going monitoring will continue through facility weekly and monthly clinical weight meetings held with the Director of Nursing, clinical managers, Certified Dietary Manager, and Registered Dietician.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495147		01/11/2017

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F 325	Continued From page 30 but were not limited to: moderate intellectual disability, anxiety disorder, DM (diabetes mellitus), dementia with behavioral disturbance, depression and dysphasia. The most current quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 assessed the resident with a cognitive score of "0", indicating the resident was severely impaired cognitively in daily decision making skills. The resident was also assessed as requiring extensive to total assistance from staff for all ADL's (activities of daily living) except for eating, where the resident was assessed as independent with set up help only. During clinical record review on 01/10/17 at approximately 1:30 p.m., Resident # 10's clinical record was reviewed. A dietary communication form dated 12/08/16 was reviewed. The form documented, "...weight seems to have dropped 9 lb from 11/1 [16] to 12/01 [16] Previously weight stable. Recommend: 1. reweigh 2. nutritional treat BID [twice daily] due to poor oral intake 3. ST [speech therapy] for most appropriate diet texture..." This form had a hand written entry that documented, "order entered speech made aware" and was signed by the DON (director of nursing). Further review of the resident's clinical record revealed a progress note dated 12/08/16 and timed 5:04 p.m., which documented: "RD [registered dietitian] Weight note: value: 155 [lbs]...5.0 % change over 30 days (5.5%, 9.0)...Resident's wt [weight] appears to have dropped 9 lb from Nov 1 to Dec 1. Weight previously stable from 160-168 lb...recommend reweigh to rule out errors in measuring. Also recommend nutritional treat BID as her meal	F 325		

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 31 intake is poor. Recommend ST evaluation to ensure finger foods diet still appropriate...signature of RD." No evidence of the resident being re-weighed could be located in the clinical record. No evidence of ST consult or evaluation could be located in the clinical record. The nutritional treat BID was initiated on 12/12/16, four days after the recommendation. A progress note dated 12/15/16 and timed 2:11 p.m., documented: "RD [registered dietitian] Weight note: value: 156...Resident discussed...her weight decreased additional 2 lb from 12/9 to 12/12. Nutritional treat BID was just started 12/12...Unclear if previous RD recommendations re: ST evaluation has been done. If not, please have ST screen to ensure current diet appropriate...signature of temporary RD." On 01/11/17 at 8:30 a.m., Resident # 10 was observed in her bed, covered with oxygen on. The resident was asked if she had breakfast, the resident stated, "no." This surveyor left the room and in the hallway outside the resident's room was a meal tray cart, the cart was opened and Resident # 10's tray was identified by a meal ticket with the resident's name. The meal tray included, two pieces of toast (open) with a piece of sausage on one side, the sausage had a piece of melted cheese on top. The crust of one piece of the toast had two small pieces (missing/eaten), a plate guard was observed, along with a cup of milk (empty) and cup of juice (full/thickened).	F 325		

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495147		C 01/11/2017

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F 325	Continued From page 32	F 325		

On 01/11/17 at 8:55 a.m., the rehab director was interviewed and was asked to provice any information on Resident # 10 regarding a speech consult or evaluation in the last 3 months.

At approximately 9:30 a.m., the rehab director presented a quarterly screen that was completed in October 2016. The rehab director stated that the screens are done every three months, automatically (on everyone) and there is no need for an order. The rehab director further stated that the last speech consult for Resident # 10 was in March of 2016, nothing since and that time the resident was recommended to have finger foods and that would include anything you can pick up with your fingers, a sandwich, french fries, anything you can eat with your hands.

At approximately 9:35, the DON was interviewed and how therapy consults/screenings are communicated to ensure completion. The DON stated that the nurses would send the information to the therapy department or they (nurses) would give it to a unit manager or to herself (DON) and then it would be forwarded to therapy. The DON was asked how long it takes to complete, once the therapy has the order. The DON stated that it doesn't normally take long, maybe a couple of days max because the ST person is here 5 days a week.

At approximately 12:40 p.m., Resident # 10 was observed again in her room, in bed with her bedside table in front of her. The resident had whole, chopped chicken, carrot slices, cubed roasted potatoes and small cup of cubed pears in liquid. A cup of juice and a cup of coffee (thickened). The resident had a fork eating the

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495147		01/11/2017

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F 325	Continued From page 33 pears with minor difficulty and left approximately 2-3 cubes in the bowl. The remainder of the food items did not look to have been touched or eaten. The resident was asked if she was going to eat her chicken, the resident stated, "No." the resident was asked about the carrots, the resident stated, "No." the resident stated, "Coffee" and then stated, "Cream." The coffee was observed black. No type of milk or creamer was observed on the resident's tray. This surveyor went out into the hall and LPN (Licensed Practical Nurse) # 1 and asked for assistance to help Resident # 10. LPN # 1 came to the room, confirmed the resident wanted cream and then took the cup to the kitchen to obtain cream. The resident again stated "No", when asked if she was going to eat anymore of her food. At approximately 2:00 p.m., the resident's meal percentages were reviewed for the month of January 2017. It was documented that the resident ate 0-25% for breakfast that morning and it was documented that the resident ate 26-50% for lunch that day. The remaining of the month January 1st through 10th, it was documented that the resident ate 0-25 % for 18 out of 30 meals and ate 26-50 % for 12 out of 30 meals. Resident # 10's current CCP (comprehensive care plan) was reviewed and documented, "Name of resident is at risk for weight loss without proper po [by mouth] intake [06/11/15]...will consume at least 50%...to promote weight maintenance and optimal nutrition. . [10/24/16]....adaptive equipment as ordered...encourage...to eat at meal time....no straws...provide diet as ordered...provide extra time...provide finger foods...provide thickened liquids..." Of the above listed interventions, the	F 325		

PRINTED: 01/20/2017
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 34	F 325		

most recent revision was on 08/01/16 for the adaptive equipment- no new interventions implemented.

At approximately 2:15 p.m., the DON stated that the ST evaluation for Resident # 10 had not been done and looked as if the "ball had dropped." The DON further stated that she could not find a re weigh for Resident # 10 until 12/15/16 (a week after the recommendation) and that she did not know why the supplement for Resident # 10 did not get implemented until four days after the recommendation.

The DON and administrator were made aware of concerns regarding Resident # 10's significant weight loss and the fact that the RD's recommendations for Resident # 10 had not been completed, in a meeting with the survey team on 01/11/17 at approximately 3:30 p.m.

No further information or documentation was presented prior to the exit conference on 01/11/17 at 4:15 p.m.

F 327 SS=E	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327		
	(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-		1) A tracking form was developed and put into place to monitor the total daily fluid intake for resident #1 and resident #14. Daily totals will be tallied by the 11-7 nurse for the previous day's totals (Prior 5 shifts) from both PCC and the ADL books to monitor resident's daily fluid intake and to monitor compliance with fluid restriction parameters. Physician reviewed both resident #1 and #14 with no negative outcomes.	2/8/2017
	(2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced			

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
NAME OF PROVIDER OR SUPPLIER: AVANTE AT WAYNESBORO		STREET ADDRESS, CITY, STATE, ZIP CODE: 1221 ROSSER AVE WAYNESBORO, VA 22980	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 327 Continued From page 35

by:
Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to follow physician orders for 1500 cc fluid restrictions. The facility staff did not monitor the total fluid intake per day for two of 19 residents, Resident #11 and Resident #14.

1. The facility staff did not monitor the total amount of fluid provided to Resident #11 to ensure a physician order for 1500 cc fluid restriction was met.

2. The facility staff failed to monitor the total amount of daily fluid provided to Resident #14 to ensure a physician ordered 1500 ml (milliliter) per day fluid restriction for cardiac and renal diagnoses was met from 8/24/16 through 1/11/17.

Findings were:

1. Resident #11 was originally admitted to the facility on 06/18/2013. Her diagnoses included but were not limited to: Type II diabetes mellitus, chronic kidney disease (Stage 4), hypertension, peripheral vascular disease, and arteriosclerotic heart disease.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/01/2016. Resident #11 was assessed as being cognitively intact with a cognitive summary score of "15".

On 01/10/2017 at approximately 2:00 p.m., Resident #11 was observed lying supine watching television in her room. Observed on her bedside

F 327

2) Any current residents that are placed on fluid restrictions as well as future admissions with fluid restrictions will have a tracking form put into place to monitor their daily intake of fluid as well as compliance with fluid restrictions.

3) On 1/11/17 in-service education was provided to licensed nurses regarding procedure for monitoring residents with fluid restrictions.

4) All residents with fluid restrictions will be reviewed during facility morning clinical meeting by the DON and/or designee to ensure compliance is maintained for 6 weeks and then randomly thereafter.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 327	Continued From page 36 table was a white Styrofoam cup with a lid and a straw.	F 327		

The electronic clinical record was reviewed on 01/10/2017. The physician orders contained the following three orders with a start date of 08/24/2016:
"1500 ml (milliliter) fluid restriction: (900 ml with meals and 600 ml provided by nursing) 7-3 = May give 240 cc 3-11=May give 300 cc 11-7 = May give 60 cc every day shift Encouraged resident to comply with restriction";
"1500 ml (milliliter) fluid restriction: (900 ml with meals and 600 ml provided by nursing) 7-3 = May give 240 cc 3-11=May give 300 cc 11-7 = May give 60 cc every evening shift Encouraged resident to comply with restriction";
"1500 ml (milliliter) fluid restriction: (900 ml with meals and 600 ml provided by nursing) 7-3 = May give 240 cc 3-11=May give 300 cc 11-7 = May give 60 cc every night shift Encouraged resident to comply with restriction".

The electronic MAR (medication administration record) was reviewed. Fluid totals were recorded by shift per day. For day shift (7-3) totals entries ranged from "60 cc" to "> [greater than sign] 500 cc" There were no total entered on the MAR for evening shift (3-11)nor was there and area available to record them. Night shift (11-7) totals ranged from "40 cc" to "120 cc".

On 01/11/2017, at approximately 8:00 a.m., Resident #11 was observed sitting up in her bed eating breakfast. On her tray was a cup of juice, milk, coffee and a white Styrofoam container with a straw was on her bedside table.

The unit manager, LPN (Licensed practical nurse)

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
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F 327	Continued From page 37 #2 was interviewed at approximately 8:15 a.m. about Resident #11's orders for her fluid restrictions. She was asked about the documentation on the electronic MAR regarding fluid intake and what all was captured in that total. She stated, "That's the total of everything she had on day shift." The unit manager was asked about the entries of greater than 500 cc and what that meant. She stated, "I will need to look at that." The unit manager left the nurse's station. LPN # 7 entered the nurses station and was asked if a resident was on fluid restrictions what would she as a nurse document on the MAR. She stated, "We only put down what nursing gives on the MAR. All the other fluid comes from dietary. The CNAs (certified nursing assistants) enter the tray totals on the ADL (activities of daily living) sheets. The unit manager then returned to the nurse's station. She stated, "I spoke with the nurse who wrote the greater than 500 down. [Name of Resident #11] 's noncompliant. The nurse writes that down because she isn't sure how much she is getting." The unit manager was asked if the white Styrofoam cup on Resident #11's bedside table is what was used by the facility to pass water. She stated, "Yes." The unit manager was then asked if residents on fluid restrictions normally have water cups at their bedsides. She stated, "No." At approximately 8:30 a.m. CNA #2 was interviewed. CNA #2 stated that she was caring for Resident #11. CNA #2 was asked about the ADL sheets. She stated, "I write down what she drinks from her tray on there. That's it." CNA #2 was asked if she knew Resident #11 was on fluid restrictions. She stated, "I don't know how many cc of fluid she is suppose to get a day." CNA #2 was asked if she had a Kardex care plan to	F 327		

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
NAME OF PROVIDER OR SUPPLIER AVANTE AT WAYNESBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 ROSSER AVE WAYNESBORO, VA 22980	

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F 327	Continued From page 38	F 327		

review for her residents. She stated, "Yes." The Kardex was obtained and reviewed. Under the section "Fluids" the entry "Fluid Restriction" was not checked, and beside the entry "Other" was written 'Encourage." The care plan was last updated "3/4/15".

LPN #7 was then interviewed regarding her entries on the MAR of greater than 500 cc of fluid intake on day shift. She stated, "I did that because I am not sure what all she has gotten...I go in the room and there are cups there. I cant record how much she had if I don't know how full the cups were from the beginning."

The care plan was reviewed. A focus area "...has a nutritional problem r/t [related to] being over IBW [ideal body weight] (145#) and diabetic ulcers. Interventions included "1500 cc FLUID RESTRICTION ORDER". There were no entries on the care plan regarding Resident #11 being noncompliant with the 1500 cc restriction

Resident #11 was interviewed on 01/11/2017 at approximately 10:00 a.m. Her breakfast tray had been removed. A white Styrofoam cup remained on her bedside table. Resident #11 was asked about the cup. She stated, "It's water. They bring it in here for me."

The DON (director of nursing) was interviewed on 01/11/2017 at approximately 1:00 p.m. She was asked about fluid restrictions for Resident #11. She stated, "I have inserviced the staff...the nurses are suppose to write only what they give to the resident on the MAR...the CNAs write the intake totals from the trays on the ADL sheets." The DON was asked if there was any place to look to see what Resident #11's totals were per

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495147		01/11/2017
NAME OF PROVIDER OR SUPPLIER AVANTE AT WAYNESBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 ROSSER AVE WAYNESBORO, VA 22980	

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F 327	Continued From page 39 day as the MAR is electronic and the ADL sheets are paper. The DON stated, "No." The DON was asked how the facility knew if Resident #11 was getting over the 1500 cc allotment per day. She stated, "There is no one place to look at those totals." The DON was asked if Resident #11 should have a water cup at her bedside. She stated, "No." The DON also stated, "[Name of Resident #11] is unable to get up on her own anymore. She cannot be noncompliant with her fluid restrictions unless she has help by someone bringing fluids in to her." The above information was discussed during a meeting with the administrator and the DON on 01/11/2017 at approximately 2:30 p.m. No further information was obtained prior to the exit conference on 01/11/2017.	F 327		
	#2. The facility staff failed to monitor the total amount of daily fluid provided to Resident #14 to ensure a physician ordered 1500 ml (milliliter) per day fluid restriction for cardiac and renal diagnoses was met from 8/24/16 through 1/11/17. The findings included: Resident #14 was admitted to the facility on 8/24/16. Diagnoses for Resident #14 included but are not limited to heart failure, diabetes (high blood sugar levels), chronic kidney disease,			

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 327	Continued From page 40	F 327		

edema (swelling) and chronic respiratory failure with hypoxia (deprived of oxygen). Resident #14's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/27/16 coded Resident #14 with no cognitive impairment. In addition, the Minimum Data Set coded Resident #14 requiring limited and extensive assistance for Activities of Daily Living care (transfers,dressing, hygiene). Resident #14 was observed on 1/11/17 at approximately 1:15 p.m. The resident was observed to be well groomed.

On 1/11/17 at approximately 1:15 pm., Resident #14 was observed during lunch drinking two cups of lemonade (8 fluid ounces each) and with the ability to eat on her own.

On 1/11/17, Resident #14's clinical record was reviewed. The reviewed showed a physician order dated 8/29/16. The order read, Resident #14 was to have a 1500 milligrams (ml) fluid restriction Every shift for fluid overload. The instructions included: 900 ml with meals and 600 ml provided by nursing); 7-3 (shift nursing staff) may give 240 cc, 3-11 shift nursing staff may give 300 cc and 11-7 shift nursing staff may give 60 cc. This order was discontinued on 1/11/17. The new order with a start date of 1/12/17 was documented on the MAR (Medication Administration Record). This order read, Resident #14 was to have a 1500 ml fluid restriction: (900 ml with meals and 600 ml provided by nursing. It was written with this instruction: 7-3= May give 240 cc, 3-11= May give 300 cc, and 11-7= May give 60 cc every shift encourage resident to comply with restriction.

Each MAR was reviewed from admission on

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/11/2017
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F 327	Continued From page 41 8/24/16 through 1/11/17 (the date of the survey when Resident #14's record was reviewed). The MAR was where the nursing staff recorded the fluid intake. The results of this reviewed: Each month had blank spaces indicating no measurement of fluid intake. Each month had amounts greater and less than the prescribed amount for the nursing staff. There was not one month were the nursing staff recorded a consistent amount of fluid as prescribed. For example, the most current month 1/1/17 through 1/31/17 recorded on the MAR : On 1/5/17 Resident #14 received 1,110 cc of fluid per nursing documentation on the MAR. On 1/5/17 and per the ADL sheets where the CNAs (Certified Nursing Assistant) record fluid intake for meals, Resident #14 received an additional total of 640 cc of fluid from breakfast and dinner. The total documented fluid intake for Resident #14 on 1/5/17 was 1,750 cc for the day. The unknown factors for Resident #14 on 1/5/17 for fluid intake included lunch because she was LOA (leave of absence) and the amount she had in between meals. The total amount of fluid for Resident #14 was unknown for 1/5/17. The clinical notes for 1/5/17 added no additional information about fluid intake. This scenario was repeated throughout the record review. Also, Resident #14 had days where she was under the fluid restriction per documentation and could have more fluid if desired. Resident #14's most current careplan did not report a refusal to comply with fluid restrictions. On 1/11/17 at approximately 1:15 p.m. Resident #14 was interviewed. Resident #14 explained that	F 327		

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 327	Continued From page 42 she had a fluid restriction because of the fluid surrounding her heart. Resident #14 stated, "I feel that I don't get enough fluids at times." From time to time she added "I will have a large white container of ice water placed on my bedside table but I don't like the water that much." On 1/11/17 at 1:30 p.m. LPN #5 (the Unit Supervisor) was interviewed. LPN #5 stated that the CNAs record fluid intake for meals on the ADL sheets and the nurses document on the MARs and if anything is different or a change that is documented on clinical notes. LPN #5 also explained that CNAs and Nurses have daily tally sheets to keep track of fluid intake throughout the shift and when the amounts are documented in the record (MAR) the tally sheets are shredded. LPN #5 also admitted that sometimes she will in-service a new staff member giving water in the large cups to the resident and she will correct them. On 1/11/17 at 1:40 p.m. LPN #6 was interviewed and added, "The resident restricts herself from fluids." LPN #6 (worked with Resident #14 on nights and days shifts) added "at times but not often when I come in I will see big cup of water in the resident's [#14] room and I will take it." On 1/11/17 at 2:05 p.m. CNA #3 (Certified Nursing Assistant) was interviewed. CNA #3 stated that she works regularly with Resident #14 from 7 a.m. through 5:00 p.m. CNA #3 stated, "I know she is on 1500 cc [fluids] so I record [in ADL sheets] in the morning her milk is 420 cc and cranberry is 180 cc. and for lunch she [Resident #14] had two large cups of lemonade which is 300 cc each." CNA #3 does not record dinner meals usually. She added, "I know we are not	F 327		

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 327	Continued From page 43 allowed to give the big Styrofoam cups of water to her but I have noticed she had the cups and I think the girls forget." CNA #3 said she takes the cups of water when she sees them in the resident's room...maybe once a week. On 1/11/17 at 1:00 p.m. the DON (Director of Nursing) was interviewed. The DON explained that the nursing staff was in-serviced (1/11/17) regarding the process of monitoring fluids after the survey team identified the inconsistencies (1/10/17) and identified the lack of a process to total the amount of fluid intake per day per resident. The DON stated, "it [fluid intake] does not get totaled for the day." When asked how she was tracking the fluid in-take, DON responded, "there is no real tracking sheet...up to this point no one was adding up the total fluid per day." The DON now has a plan to change this that begins with the in-servicing staff. The Administrator and DON did not have a facility policy to present. The facility administration was informed of the findings during a briefing on 1/11/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.	F 327		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's	F 328	1) Resident #12s oxygen was immediately re-applied at the prescribed flow rate of 4liters. CNA #1 was re-educated on resident #12s need for oxygen while in bed as well as when up in wheelchair. Resident #12s kardex was updated to reflect oxygen requirements.	2/8/2017

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328 Continued From page 44

medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

F 328

2). A 100% kardex audit was completed on all current residents who require oxygen to ensure correct documentation of oxygen need is in place as well as liter flow for review by staff members caring for residents.

3) In-service education was started on 1/13/17 for licensed nurses and certified nursing assistants regarding appropriate oxygen information needed on resident's kardex in order to ensure appropriate care is provided to each individual resident in accordance with their specific plan of care.

4) Kardex's will be reviewed on any resident who has a new order for oxygen as well as on all new admissions to ensure that they include the appropriate information for staff to provide care for the resident as ordered. Audits will be completed twice weekly for 6 weeks and as needed thereafter by unit managers/DON/ and/or designee.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

PRINTED: 01/20/2017
FORM APPROVED
CMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328	Continued From page 45	F 323		

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed to ensure that physician ordered oxygen was in place for one of 19 residents, Resident #12.

Resident #12 did not have her oxygen on as ordered while in the dining room from approximately 11:10 a.m. until 1:20 p.m.

Findings were:

Resident #12 was admitted to the facility on 04/01/2016. Her diagnoses included but were not limited to: Pneumonia, urinary tract infection, dysphagia, unspecified heart failure and dementia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/2/2016. Resident #12's cognitive status was assessed as "moderately impaired" with a summary score of "9".

On 01/11/2017 at approximately 8:30 a.m. Resident #12 was observed lying in bed. A nasal cannula was in place with oxygen running at 4 liters.

The electronic clinical record was reviewed. The

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/11/2017
NAME OF PROVIDER OR SUPPLIER AVANTE AT WAYNESBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 ROSSER AVE WAYNESBORO, VA 22980	

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F 328	Continued From page 46	F 328		

physician order sheet contained the following order: "Oxygen 4 LPM [liters per minute] per nasal cannula every shift related to HEART FAILURE, UNSPECIFIED."

On 01/11/2017 at approximately 11:10 a.m., Resident #12 was observed sitting in her wheelchair in the dining room. She was not wearing her oxygen.

At approximately 12:10 p.m., Resident #12 was fed her lunch in the dining room by a staff member. She was not wearing her oxygen. An oxygen tank was observed on the back of her wheelchair but there was no nasal cannula attached nor was the tank on.

At approximately 1:20 p.m., Resident #12 was wheeled back to her room. CNA #1 was in the room getting Resident #12 to lie back down. Resident #12 was pleasant and chatting with this surveyor. She was asked if she was breathing okay. She stated, "Yes." Resident #12 was asked why she was not wearing her oxygen. CNA #1 stated, "I was told she only needs it in bed."

CNA #1 assisted Resident #12 back to bed and reapplied the oxygen.

The Kardex and care plan were reviewed. Under the area "Respiratory" on the Kardex oxygen was checked but there was no mention of the amount of oxygen ordered or when Resident #12 was to wear it.

During an end of the day meeting on 01/11/2017 at approximately 2:30 p.m., the DON (Director of Nursing) and the administrator were informed of

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F 328	Continued From page 47 the above information and that Resident #12 had been without her oxygen for over two hours earlier that day (01/11/2017). No further information was obtained prior to the exit conference on 01/11/2017.	F 328		
F 406 SS=D	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 19 residents received specialized rehabilitative services after a physical decline and to ensure prevention of further decline; Resident # 10. The facility failed to complete a physician ordered ST (Speech Therapy) consult/evaluation after a significant weight loss of 9 lbs (pounds) in one	F 406	1) Speech consult was completed on 1/12/17 for resident #10 with no new changes to current medical orders. 2) An audit of the past 3 months of Registered Dietitian notes was completed with no other issues/ concerned noted. 3) All residents who have speech therapy consult recommendations from the Registered Dietician will have a therapy referral form completed by Director of Nursing or designee to ensure timely evaluation and treatment. Director of Nursing and clinical managers were in serviced. 4) The Director of Nursing and/ or designee will monitor any recommendations from the Registered Dietician for 6 weeks and randomly thereafter. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	2/8/2017

F 406

F 406 Continued From page 48
month for Resident # 10.

Findings include:

Resident # 10 was admitted to the facility on 09/23/97, with the most current readmission on 07/01/08. Diagnoses for Resident # 10 included, but were not limited to, moderate intellectual disability, anxiety disorder, DM (diabetes mellitus), dementia with behavioral disturbance, depression and dysphasia.

The most current quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 assessed the resident with a cognitive score of "0" indicating the resident was severely impaired cognitively in daily decision making skills. The resident was also assessed as requiring extensive to total assistance from staff for all ADL's (activities of daily living) except for eating, where the resident was assessed as independent with set up help only.

During clinical record review on 01/10/17 at approximately 1:30 p.m., Resident # 10's clinical record was reviewed. A dietary communication form dated 12/08/16 was reviewed. The form documented, "...weight seems to have dropped 9 lb from 11/1 [16] to 12/01 [16] Previously weight stable. Recommend: 1. reweigh 2. nutritional treat BID [twice daily] due to poor oral intake 3. ST [speech therapy] for most appropriate diet texture..." This form had a hand written entry that documented, "order entered speech made aware" and was signed by the DON (director of nursing).

Further review of the resident's clinical record revealed a progress note dated 12/08/16 and timed 5:04 p.m., which documented: "RD

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F 406	Continued From page 49 [registered dietitian] Weight note: value: 155 [lbs]...5.0 % change over 30 days (5.5%, 9.0)...Resident's wt [weight] appears to have dropped 9 lb from Nov 1 to Dec 1. Weight previously stable from 160-168 lb...recommend reweigh to rule out errors in measuring. Also recommend nutritional treat BID as her meal intake is poor. Recommend ST evaluation to ensure finger foods diet still appropriate...signature of RD." No evidence of ST consult or evaluation could be located in the clinical record. A progress note dated 12/15/16 and timed 2:11 p.m., documented: "RD [registered dietitian] Weight note: value: 156...Resident discussed...her weight decreased additional 2 lb from 12/9 to 12/12. Nutritional treat BID was just started 12/12...Unclear if previous RD recommendations re: ST evaluation has been done. If not, please have ST screen to ensure current diet appropriate...signature of temporary RD." On 01/11/17 at 8:55 a.m., the rehab director was interviewed and was asked to provide any information on Resident # 10 regarding a speech consult or evaluation in the last 3 months. At approximately 9:30 a.m., the rehab director presented a quarterly screen that was completed in October 2016. The rehab director stated that the screens are done every three months, automatically (on everyone) and there is no need for an order. The rehab director further stated that the last speech consult for Resident # 10 was in March of 2016, nothing since and that time the resident was recommended to have finger foods	F 406		

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F 406	Continued From page 50	F 406		

and that would include anything you can pick up with your fingers, a sandwich, french fries, anything you can eat with your hands.

At approximately 9:35, the DON was interviewed and how therapy consults/screenings are communicated to ensure completion. The DON stated that the nurses would send the information to the therapy department or they (nurses) would give it to a unit manager or to herself (DON) and then it would be forwarded to therapy. The DON was asked how long it takes to complete, once the therapy has the order. the DON stated that it doesn't normally take long, maybe a couple of days max because the ST person is here 5 days a week.

Resident # 10's current CCP (comprehensive care plan) was reviewed and documented, "Name of resident is at risk for weight loss without proper po [by mouth] intake [06/11/15]...will consume at least 50%...to promote weight maintenance and optimal nutrition... [10/24/16]....adaptive equipment as ordered...encourage...to eat at meal time....no straws...provide diet as ordered...provide extra time...provide finger foods...provide thickened liquids as ordered by physician/ST..." Of the above listed interventions, the most recent revision was on 08/01/16 for the adaptive equipment- no new interventions implemented.

At approximately 2:15 p.m., the DON stated that the ST evaluation for Resident # 10 had not been done and it looked as if the "ball had dropped."

The DON and administrator were made aware of concerns regarding Resident # 10's ST evaluation not being completed after a significant weight

F 406 Continued From page 51

loss, in a meeting with the survey team on 01/11/17 at approximately 3:30 p.m.

No further information or documentation was presented prior to the exit conference on 01/11/17 at 4:15 p.m.

F 431 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who—

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted

F 406

F 431 2/8/2017

1) The bottle of opened/undated hemoccult solution and the opened/undated bottle of Lantus insulin were discarded on 1/12/17.

2) 100% audit was completed on all medication carts and medication rooms to ensure no other unlabeled medications were present. No other issues were found.

3) In-service education started 1/13/17 with licensed nurses staff on the proper labeling of all opened medications on medication carts and in medication room.

4) Medication cart and medication room audits will be completed twice weekly for 6 week and as needed thereafter by Director of Nursing/Unit Managers/ and/or designee to ensure facility remains in compliance with state regulations.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

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F 431	Continued From page 52	F 431		

F 431 Continued From page 52

professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, facility staff failed to ensure drugs and biologicals were stored properly in one of two medication rooms, the B-Wing.

Facility staff failed to date an open bottle of Lantus insulin and an open bottle of Hemoccult developer upon initial use.

Findings included:

The medication room on the B-Wing was observed 01/11/17 at 12:45 p.m. by this surveyor and LPN #4 (licensed practical nurse). During this observation a bottle of Hemoccult developer was discovered as opened and not dated. LPN

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F 431	Continued From page 53 #4 stated, "Oh, it doesn't have a date on it. We don't use very often. I will discard this since there isn't an open date on the bottle." An open bottle of Lantus insulin 100u/ml (units/milliliter) was observed in the medication refrigerator. No open date was visible on the bottle. This insulin belonged to a current resident in the facility who receives 52 units SQ (subcutaneously) Qhs (every bedtime). LPN #4 stated, "I don't know why this is in the refrigerator opened and not dated. Opened insulin bottles are usually kept on the medication cart. I will talk with (Name) DON (director of nursing) and see what she wants me to do with it." The Administrator and DON were informed of the above findings during a meeting with the survey team on 01/11/17 at approximately 3:00 p.m. No further information was received by the survey team prior to the exit conference on 01/11/17.	F 431		