STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495416	A. BUILDING ______ B. WING ______	06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY PONDS INC	21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147

(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 Federal Comparative Survey was conducted at Ashby Ponds Inc. June 5, 2017 through June 8, 2017. Survey activities consisted of a review of 7 resident clinical records during Phase I; review of 11 resident clinical records during Phase II; observations of staff practices; review of the facility's operating procedures; and interviews with residents, families, and facility staff. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(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.	F 225		7/23/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/30/2017

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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(4) Report to the State nurse aide registry or 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

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if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to report an allegation of abuse to the state agency for two of 18 residents in the survey sample, Residents #12 and #10.

1. The facility staff failed to report two allegations of abuse made by Resident #12 by facility staff on 11/27/16 and 1/27/17 to the state agency through established procedures.

2. The facility staff failed to report an allegation of abuse made by Resident #10 against facility staff on 4/11/17, to the state agency through established reporting procedures.

The findings include:

Resident #12 was admitted to the facility on 4/10/14 with diagnoses including, but not limited to: Dementia, Peripheral Vascular Disease, Diabetes and Anxiety.

A review of the facility concern/complaint log revealed the following entries: "Name: [Resident #12]; Date complaint received: 11/27/16; Nature of Complaint: Abuse, customer service; Disposition/Resolution Date:11/28/16; Disposition/Resolution Action: interviews, different accounts; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: [the Administrator)].
Name: [Resident #12]; Date complaint received: 1/27/17; Nature of Complaint: Abuse allegation;

Provider's Plan of Correction (F 225):

1. The facility followed up on all the concerns for residents #12 and #10 listed during the
state visit.

2. The administrator or designee will audit the current concern and incident report log for any allegations of abuse that meet the criteria for reporting.

3. Staff will be educated on the facility policy for abuse prevention, policies and reporting by the staff development coordinator (SDC) or designee.

4. NHA or designee will monitor concern logs or any allegations of abuse and ensure reports are made per guidelines. Audits will be completed monthly for 3 months. Findings from these audits will be reported and reviewed at monthly QA/QI meeting for review and further direction as appropriate.

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F 225	Continued From page 3 Disposition/Resolution Date: 1/30/17; Disposition/Resolution Action: SW (social worker) meeting; res (resident) wanted staff fired; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: Administrator." On 6/7/17 at 3:10 PM, the DON (Director of Nursing), was interviewed regarding the concern/complaint log. The files contained no documents related to reporting to the state agency. Resident #10 was admitted to the facility on 3/21/17 and readmitted on 4/4/17 with diagnoses including, but not limited to: history of Atrial Fibrillation and Dementia. A review of the facility concern/complaint log revealed the following entry: "Name: (Resident #10); Date complaint received: 4/11/17; Nature of Complaint: Abuse allegation; Disposition/Resolution Date: 4/14/17; Disposition/Resolution Action: staff education; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: the Administrator." The DON acknowledged that the facility failed to report the abuse allegation to the state agency on 4/11/17 where facility staff allegedly abused Resident #10.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement	F 226		7/23/17

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F 226	Continued From page 4 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 document review, and clinical record review, it was determined that the facility staff failed to implement and follow abuse policies and procedures for reporting allegations of abuse to the state agency in accordance with federal regulations for two of 18 residents in the survey sample, Residents #12 and #10. The facility also	F 226	1. The facility followed up on all concerns for residents #12 and #10 listed during the state visit in accordance with our abuse policy. 2. The administrator or designee will audit the current concern and incident report log for any allegations of abuse that	

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F 226	Continued From page 5 failed to ensure the safety of one resident (Resident #4) after an allegation of abuse was reported by not immediately suspending the accused perpetrator. The findings include: 1. The facility staff failed to follow the facility abuse policy to report an allegation of abuse made by Resident #10 against facility staff on 4/11/17 to the state agency. 2. The facility staff failed to follow the facility abuse policy to report to the state agency two allegations of abuse by staff made by Resident #12 on 11/27/16 and 1/27/17. 3. The facility also failed to ensure the safety of one resident (Resident #4) after an allegation of abuse was reported by not immediately suspending the accused perpetrator. Resident #12 was admitted to the facility on 4/10/14 with diagnoses including, but not limited to: Dementia, Peripheral Vascular Disease, Diabetes and Anxiety. A review of the facility concern/complaint log revealed the following entries: "Name: [Resident #12]; Date complaint received: 11/27/16; Nature of Complaint: Abuse, customer service; Disposition/Resolution Date: 11/28/16; Disposition/Resolution Action: interviews, different accounts; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: the Administrator. Name: [Resident #12]; Date complaint received: 1/27/17; Nature of Complaint: Abuse allegation; Disposition/Resolution Date: 1/30/17;	F 226	meet the criteria for reporting and for any concern or incident to assure that the accused perpetrator is suspended per policy. 3. The SDC or designee will educate current on the facility policy for abuse prevention, policies and reporting. New employees will be educated on the facility policy for abuse prevention, policies and reporting prior to working on any care neighborhood. 4. The administrator or designee will audit concern logs or any allegations of abuse and ensure reports are made per guidelines monthly for 3 months. Findings from these audits will be reported and reviewed at monthly QA/QI meeting for review and further direction as appropriate. 4. The new Erickson abuse policy has been included into all new employee orientation. New employees will be trained on the policy prior to working on any care neighborhood. Annual and ongoing training will be completed by all staff in continuing care. The NHA or designee will review all training for new hires for three consecutive months beginning in June 2017. Findings from these audits will be reported and reviewed at monthly QAIQI meeting.	

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Disposition/Resolution Action: SW (social worker) meeting; res (resident) wanted staff fired; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: the Administrator.."

On 6/7/17 at 3:10 PM, the Administrator, was interviewed. He stated if a resident alleges abuse or mistreatment against a staff member, that staff member should be removed from the building and from the subsequent schedule until an investigation can be completed. "The Administrator was asked if these two allegations of abuse made by Resident #12 should have been reported to the state agency. The Administrator stated: "Yes, they should be reported."

Resident #10 was admitted to the facility on 3/21/17 and readmitted on 4/4/17 with diagnoses including, but not limited to: Atrial Fibrillation and Dementia.

A review of the facility concern/complaint log revealed the following entry: "Name: [Resident #10]; Date complaint received: 4/11/17; Nature of Complaint: Abuse allegation; Disposition/Resolution Date: 4/14/17; Disposition/Resolution Action: staff education; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: the administrator."

On 6/8/17 at 3:10 PM, the Administrator was interviewed. He stated if a resident alleges abuse or mistreatment against a staff member, that staff member should be removed from the building and from the subsequent schedule until an investigation can be completed. He stated the

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resident should be interviewed, if possible. When asked what these guidelines require, he stated: "We report the allegation within 24 hours. We complete our investigation, and then we send a final report within five days." The Administrator was asked if this allegation of abuse made by Resident #10 on 4/11/17 should have been reported to the state agency. He stated: "Yes."

A review of the facility policy, "Abuse Prevention" revealed, in part, the following: "Investigation: The community will investigate all suspected or alleged incidents of resident abuse, mistreatment, neglect, exploitation, involuntary seclusion, and misappropriation of property. Reporting: The community will report incidents of abuse or alleged abuse per Federal, State, and local laws...The individual should notify the Administrator or designee as soon as possible within the time frames listed above so that the facility can report the incident to the Secretary within the required time frames. Upon receiving the report from the covered individual, the Administrator or designee assumes the responsibility for reporting the matter to the required authorities. The individual may also report the incident directly." A review of the facility policy "Abuse Reporting and Investigation" revealed, in part, the following: "[Name of corporation] is committed to providing an environment where residents' rights are protected and residents remain free from abuse, neglect, exploitation, and misappropriation of property. To this end, [name of corporation] has adopted a standard of zero tolerance of such incidents in our community, and will assure that all allegations of abuse, neglect, exploitation and misappropriation of resident property are reported or (sic) required by federal, state, and local laws,

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and investigated promptly. In addition, staff who work in our communities will be knowledgeable of [name of corporation] abuse prevention and investigation policies and protocols and state/local regulations...Upon receiving notice of an allegation covered in this policy, Executive Director, Nursing Home Administrator/Assistant Administrator or designee initiates an investigation and ensures notification of the appropriate State agencies of the allegation (as provided by law and within 24 hours). The Executive Director/Nursing Home Administrator must lead the community in cooperation with any state agency investigation as applicable...Although a resident may have cognitive impairment (mild or severe) allegations of abuse received from these residents should be taken seriously."

Review of the facility policy titled, "Abuse Reporting & Investigation" indicated under section B number 6, "Any staff member who is believed to be involved in an alleged abuse or neglect situation is placed on leave pending the outcome of the investigation."

On 3/27/17 at 1:00 PM, the facility received an allegation of abuse from Resident #4 regarding Employee #3.

Review of facility documentation revealed that Employee #3 continued to work and provide care to Resident #4 after the allegation was made. According to time clock data, Employee #3 punched out at 8:36 PM on 3/27/17.

In an interview with the Corporate Nurse on 6/6/17 at approximately 2:15 PM, she stated that Employee #3 was not suspended per facility

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F 226	Continued From page 9 policy.	F 226		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on review of clinical records, interview and observations, it was determined the facility failed to ensure 1 resident (Resident #10) of 18 sampled residents was provided dignity with the use of their bed side drainage bag. The findings include: Resident #10 was admitted to the facility 3/21/17 with diagnoses including Cardiovascular Accident with left hemiparesis and Acute Urinary Retention with indwelling catheter. Review of the "Admission Minimum Data Set" (MDS) dated 4/11/17 and the "significant change MDS" dated 6/5/17 documented Resident #10 was assessed for a continuous indwelling catheter. On 6/7/17 at 11:40 a.m., 6/7/17 at 1:35 PM and 6/8/17 at 9:30 AM, Resident #10 was observed in bed without a privacy bag covering the bedside catheter drainage bag. During interview on 6/8/17 at 10:20 AM, the Director of Nursing verified the catheter bed side drainage bag should be covered for privacy.	F 241	1. The facility immediately placed a privacy bag for resident # 10 covering the bedside catheter drainage bag. 2. A 100% audit of current residents with bedside catheter drainage bags will be conducted to ensure that a catheter drainage bag is in place . 3. The SDC or designee will educate the nursing staff on the facility policy for urinary catheters which includes utilization of a dignity cover for the catheter drainage bag. 4. DON or designee will complete a 100% audit of all residents with catheters monthly for 3 months. All audit findings will be reported to our monthly QA/QI meetings for review and further direction as appropriate.	7/23/17
F 279	DEVELOP COMPREHENSIVE CARE PLANS	F 279		7/23/17

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CFR(s): 483.20(d);483.21(b)(1)

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 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

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F 279	Continued From page 11 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 record review and staff interviews, it was determined that the facility failed to ensure that a care plans was developed for 1 resident (Resident #4) regarding cognition in a timely manner. The survey sample consisted of 18 residents. The findings include: Resident #4 Review of Resident #4's clinical record indicated that the resident was admitted to the facility on 9/17/15 with diagnoses that included Depression, Hypertension, Seizures and Anxiety. The Minimum Data Set Assessment (MDS) dated	F 279	1. A comprehensive care plan was developed based on the care area assessment triggers from the MDS assessment dated 3/8/17 for resident #4. This was completed as of May 25, 2017. 2. A review of admissions for the past 30 days will be completed to ensure that a comprehensive care plan was initiated and the comprehensive care plan was developed based on the care area assessment triggers. 3. The SDC or designee will in service licensed nursing staff including our MDS nurse on the facility policy for the	

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F 279	Continued From page 12 3/8/17 indicated that a care plan should be developed regarding cognition. Review of Resident #4's care plan revealed that a care plan for cognition was not developed after that assessment. In an interview with the Registered Nurse Assessment Coordinator on 6/8/17 at approximately 10:00 AM, she stated that the care plan was not developed after the 3/8/17 assessment. She stated that a cognition care plan was not developed until 5/18/17. She stated she added a care plan for cognition when the state agency surveyor pointed out there was no cognition care plan in Resident #4's clinical record.	F 279	development of comprehensive care plans based on the care area assessment triggers. 4. ADON or designee will audit records of new admissions for initiation and completion of comprehensive care plans based on the care area assessment triggers. A random monthly audit will be completed for three months. Audit findings will be reviewed at the QA/QI committee for review and further direction as appropriate.	
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 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 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		7/23/17

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F 309

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practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(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 record review and staff interview, it was determined that the facility failed to follow physicians' orders for 2 residents regarding an anti-anxiety medication administered for pain for Resident #2 and for failing to obtain a neurological consult as ordered for Resident #4.

The findings include:

Resident #2
Review of Resident #2's clinical record indicated that the resident was admitted to the facility on 8/4/16 with diagnoses that included Pain, Dementia and Hypertension.

Resident #2 had a physician's order dated 8/4/16 for Ativan, an anti-anxiety medication, 0.5 milligrams every 6 hours as needed for anxiety.

Review of a Nursing Clinical Note dated 11/14/16

F 309

1. Resident # 2 medication regimen was reviewed by physician to ensure appropriateness .
Resident #4 Physician to assess the current need for a neuro consult and this will be completed by 6/30/17.
2. The ADON or designee will conduct a 100% audit of current residents prescribed an anti-anxiety medication to ensure physician orders are followed. The ADON or designee will audit all current residents with an order for a neurological consult to assure completion of consult.
3. The SDC or designee will in service licensed nursing staff on the facility psychoactive medication policy including its proper usage and obtaining physician ordered consults..
4. ADON or designee will complete a random audit of anti-anxiety medications

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F 309	Continued From page 14 read, "Tylenol was given by previous shift nurse at 0600 (6 AM). Not effective. guest states pain is 10/10 for headache and neck pain. administered Ativan until new orders from NP (Nurse Practitioner) for hydromorphone are available." In an interview with the Corporate Nurse on 6/6/17 at approximately 2:00 PM, she stated that the Ativan was not ordered for pain and should not have been administered by the nurse. Resident #4 Review of Resident #4's clinical record indicated that the resident was admitted to the facility on 9/17/15 with diagnoses that included Depression, Hypertension, Seizures and Anxiety. Resident #4 had a physician's order for a neurological consult dated 3/2/17. Review of the clinical record failed to reveal that the consult had been performed. In an interview with the Director of Nursing on 6/7/17 at approximately at approximately 2:00 PM, she stated that the consult was not done.	F 309	monthly for 3 months to ensure physician orders are followed for use of anti-anxiety medications. The ADON or designee will complete a random audit of residents with neurological consult orders to assure completion of consult. All audit findings will be reviewed at the monthly QA/QI meeting for review and further direction as appropriate.	
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 314		7/23/17

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F 314	Continued From page 15 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that a pressure ulcer dressing change was done with aseptic technique for one of 18 sampled residents (Resident #3). The findings include: Resident #3 was admitted to the facility on 1/8/16 with diagnose including Difficulty Walking, Syncope, Aphasia and Urine Retention. On 6/7/17 at 11:15 AM, during observation of a pressure ulcer dressing change, Employee #2 placed the dressing change equipment on the over-bed table of Resident #3. The Employee washed her hands and gloved. She then removed Resident #3's soiled diaper and changed gloves without washing her hands. She then re-gloved and removed the soiled dressing from a Stage 2 pressure ulcer on the Resident #3's inner thigh. She then measured the wound as 0.1 cm (centimeter) x (by) 0.2 cm. She again removed and changed her gloves without washing her hands. She then applied wound cleanser then changed	F 314	1. Resident #3 had no effects related to the improper dressing change. Employee # 2 was educated on the proper hand washing procedure in adherence with Erickson policy. This was completed on 6/14/17. 2. The DON or designee will conduct A 100% audit of current residents with pressure ulcers to observe for proper hand washing procedures during dressing changes. This will be completed by 7/7/17. 3. The SDC or designee will in service licensed nursing staff on the facility policy for proper hand washing procedures while performing pressure ulcer dressing changes by 7/7/17. 4. DON or designee will complete a random audit of proper hand washing procedures during wound treatments monthly X 3 months starting July 2017. All findings from audits will be reported at the monthly QA/QI meeting for review and further direction as appropriate.	

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F 314	Continued From page 16 gloves without washing her hands and applied Hydrocholoid dressing. She then removed her gloves and again re-gloved without washing her hands. She then discarded the supplies on the over bed table into a trash can and then washed her hands for the second time since starting the procedure. In an interview with the Director of Nursing on 6/7/17 at 3:00 PM, it was her expectation that handwashing would be done frequently during pressure ulcer dressing changes.	F 314		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		7/23/17

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483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, it was determined that the facility failed to use non-pharmacological interventions prior to the administration of 0.5 mg (milligram) of Ativan (antianxiety medication) prn (as needed) for 3 of 18 sampled residents in the survey sample (Resident #8, #7 and #10).

The findings include:

Resident #8
Resident #8 was admitted to the facility on 11/19/15 with diagnoses that include Muscle Weakness, Crone's Disease, End Stage Renal Disease.

On 6/7/17 at 2:00 PM, a clinical record review revealed a physician's order for Ativan 0.5 mg every 8 hours as needed.

In May 2017 Resident #8 received the prn Ativan

Provider's Plan of Correction:

1. The physician was notified that PRN Ativan was administered to residents # 7, #8 and # 10 without documentation of non-pharmacological intervention on June 30,2017.

2. The DON or designee will complete A 100% audit of all clinical records for current residents receiving antianxiety medications to ensure the presence of documentation of non-pharmacological interventions. This will be completed by 7/7/17.

3. The SDC or designee will educate the Medical providers and licensed nurses on the facility policy to ensure residents with anti-anxiety medications have documentation of non-pharmacological interventions. This will be completed by 7/7/17.

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on 20 occasions. The clinical record lacked any documentation of non-pharmacological interventions being attempted prior to administration of the prn mediation.

In June 2017 Resident #8 received the prn Ativan on 5 occasions without any non pharmacological interventions being documented prior to administration of the medication.

On 6/8/17 at 2:40 PM, in an interview with the Director of Nursing, it was acknowledged that if there was no documentation in the clinical record of non-pharmacological interventions being documented, they were not attempted.

Resident #10
Resident #10 was admitted to the facility 3/21/17 with diagnoses including Dementia without behaviors, Depressive Disorder and Anxiety.

Review of the May 2017 "Medication Administration Records" (MAR) revealed on 4/04/17, Resident #10 had a physician order to receive Ativan 0.5 milligrams (mg) every four hours as needed (prn) for anxiety. Further review of the May 2017 MAR revealed Resident #10 received Ativan 0.5 milligrams on 5/2/17 at 10:13 PM, 5/18/17 at 10:02 PM, and 5/24/17 at 3:42 AM.

The clinical record lacked documentation of any non-pharmacological interventions prior to the administration of the prn Ativan.

During an interview on 6/8/17 at 2:40 PM, with the Administrator and the Director of Nursing (DON), it was confirmed that Resident #10's MAR clinical record did not document any

F 329

4. DON or designee will audit clinical records of residents receiving antianxiety medications for the presence of no pharmacological interventions. Audits will be completed monthly for 3 months beginning in July 2017. All findings from audits will be reported at our monthly QA/QI meeting for review and further direction as appropriate.

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F 329	Continued From page 19 non-pharmacological interventions by staff prior to the administration of the prn Ativan. Resident #7 Resident #7 was admitted to the facility on 5/23/2017 with diagnoses including a Brain Mass and, Cerebral Edema Review of the 6/5/17 "Minimum Data Set" (MDS) - a comprehensive assessment completed by facility staff that drives the care planning process), with an assessment reference date of 6/5/2017, revealed the resident had a BIMS (brief interview of mental status) score of 2, indicating the resident was severely cognitively impaired. The 5/23/2017 "Physician Orders" documented an order for Ativan, (an antianxiety medication) 0.5 mg tablet to be given as needed (prn) for anxiety every 6 hours. Review of the resident's MAR revealed Ativan had been administered to Resident #7 on 5/26/17 at 8:00 AM. There was no documented evidence of non-pharmacological interventions being offered to the resident on the MAR or the on the "Nursing Notes" dated 5/26/17. Also, review of the "Nursing Notes" dated 5/26/27 revealed there was no documented evidence of any sign of anxiety for the resident. On 6/8/2017 at 10:14 AM, the Director of Nursing stated it was her expectation that non-pharmacological interventions be attempted before a resident was administered an anti-anxiety medication.	F 329		
F 356 SS=C	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4)	F 356		7/23/17

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F 356	Continued From page 20 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data.	F 356		

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F 356	Continued From page 21 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility staffing sheets, it was determined that the facility failed to document the facility name and daily census on the Facility Daily Nursing Staff Data sheets. The findings include: On 6/7/17 at 3:00 PM, the Facility Daily Nursing Staff Data completed forms were requested from the facility's Director of Nursing (DON). The list requested was between 5/10/17 until 6/7/17. The Staff Data sheets all lacked the name of the facility and a daily census for the entire period of time. In an interview with the DON on 6/7/17 at 3:00 PM, it was acknowledged that the Facility Daily Nursing Staff Data sheets all lacked the name of the facility and the daily census.	F 356	1. The name of the facility and the daily census each shift was immediately added to our posted nursing staffing information sheet. This was effective 6/8/17. 2. The DON or designee will complete A 100% audit to ensure that staffing sheets contain the facility name and current census per shift. 3. The DON or designee will in service the Nursing Staff and unit secretary on the proper requirements for the daily nursing staffing sheet. This will be completed by 7/7/17. 4. DON or designee will complete random nurse staffing sheet audits X 3 months. All findings will be reported to monthly QA/QI meeting for review and further direction as appropriate.	
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		7/23/17

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(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on review of the clinical record, interview and observation, the facility failed to ensure food was prepared in a manner minimizing the risk for food-borne illness for all 41 residents who resided in the nursing facility and received nourishment from the kitchen.

The findings include:

The initial kitchen observation was conducted on 6/5/17 at 2:59 PM, with the dietary manager (DM) present. The back splash behind the stove and grill were soiled with food splashes and streaks. The gas burners on the gas stove were soiled with food crumbs and food debris. The grill burners were soiled with dried food debris. The

1. The Kitchen areas including the gas stoves, grill burners and the grease trap were immediately cleaned on 6/5/17 and 6/7/17. Also, a beard net was immediately put on for the dietary member noted without one on 6/8/17.
2. The dietary manager will complete a 100% audit of all gas stoves, grill burners, grease traps and beard nets will be completed by 7/7/17.
3. All dietary staff will be educated by the dietary manager on the policies regarding food and sanitary procedures. This education will be complete by 7/14/17.
4. Dietary Manager will conduct a random monthly audit of gas stove, grill

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F 371	Continued From page 23 grease reservoir situated directly in front of the grill for scrapings was soiled with grease and had accumulated food scrapings and debris. On 6/7/17 at 7:22 AM, a second observation of the kitchen was completed. The grill and reservoir remained soiled with accumulated crumbs of food and debris. This was confirmed with the chef during interview 6/7/17 at 7:25 AM. On 6/8/17 at 9:15 AM, a dietary staff member was observed serving and plating food in the kitchen with his full beard uncovered. Review of the facility's policy titled, "Dress Code - Staff preparing and Handling food" dated 10/1/07 indicated that facial hair required a cover.	F 371	burner and grease trap cleanliness. The dietary manger will also include beard nets in the monthly audit and will complete this audit for 3 months starting in July 2017. All findings will be reported to the monthly QA/QI meeting for review and further direction as appropriate.	
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (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-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to ensure that medications for 2 residents were safely and securely stored (Residents #4 an #18).	F 425	1. Resident's #18 and #4 immediately had their medication cabinets secured under lock on 6/5/17. 2. The NHA or designee will conduct A 100% audit of all medication cabinets will	7/23/17

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F 425	Continued From page 24 The findings include: Observations during the initial tour of the facility on 6/5/17 at approximately 3:20 PM, accompanied by the Registered Nurse Assessment Coordinator (RNAC) revealed unsecured medications in room 135 and room 137. In Resident #18's room (137) unsecured medications were in an unlocked wall cabinet. The medications were: Aspirin 81 milligrams (mg.) - 2 tablets Neurontin 100 mg. - 5 tablets Methocarbimol 500 mg. - 26 tablets Pantoprazole 40 mg. - 24 tablets Clopidogrel 75 mg. - 17 tablets Avastin 10 mg. - 21 capsules In Resident #4's room (135) unsecured medications were in an unlocked wall cabinet. The medications were: Metropolol 50 mg. - 25 tablets Spironolactone 25 mg. - 16 tablets Fluoxetine 20 mg. 11 capsules Famotidine 20 mg. - 2 tablets Cilostazol 100 mg. - 8 tablets In an interview with the RNAC at the times of the observations, she stated that the wall cabinets should have been locked.	F 425	be to ensure that medications are securely and safely stored. This audit will be completed by 6/30/17. 3. The SDC or designee will in service the Licensed nursing staff on the facility policy for ensuring resident medications are safely and securely stored . 4. NHA or designee will complete random monthly audits ensure that all medication cabinets are secure. These monthly audits will begin in July 2017 and last 3 months. All findings will be reported to the monthly QA/QI meeting for review and further direction as appropriate.	
F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		7/23/17

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	495416	A. BUILDING ______ B. WING ______	06/08/2017

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F 441	Continued From page 25	F 441		

and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 441	Continued From page 26 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to maintain a complete infection control program as evidenced by incomplete infection control tracking logs for July, August, September, and October 2016. In addition, the facility failed to identify organisms for 123 reported infections out of a total of 144 infections identified on the facility Infection Monitoring Log, from 5/10/16 until 5/26/17. The facility also failed to perform a two-step Tuberculosis screening for a new employee 7 days prior to the first date of employment. The findings include:	F 441	1. The facility is unable to recreate the missing infection control logs from July-October 2016. As of April 2017, we use a more in-depth infection control tracking program to that ensure we met all standards of the infection prevention and control program to include tracking of organisms. 2. The DON/designee will conduct A 100% audit of all infection logs dating back to May 2017 to ensure completion of the infection control log and the identification of organisms. The NHA or designee will conduct a 100 % audit of all new hires in the month of June to ensure	

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F 441	Continued From page 27 On 6/7/17 at 9:30 AM, the survey team requested the Director of Nursing (DON) to provide the control monthly logs dating back to May 2016. The DON provided logs listing infections by month, including resident names, room numbers, infection locations, resolved dates for all months since the previous survey except for July, August, September, and October 2016. However, the logs failed to identify organisms for 123 of 144 infections noted on the Infection Monitoring Log. On 6/8/17 at 10:25 AM, the DON was interviewed. When asked about the missing infection control logs, she stated: The logs cannot be located for the missing logs between July and October 2016. When asked if she had completed the logs with respect to the organisms, she stated she had not. She stated she was not aware of anywhere the logs might be located. When asked the purpose of completing the monthly logs, the DON stated: "So we can track and trend the infections in the facility." On 6/8/17 at 12:15 PM, the Administrator and DON were notified about the concerns regarding the missing logs and facility failure to identify organisms. Review of the facility policy titled, "Tuberculosis Screening," indicated that a new hire had to submit the results of a tuberculosis risk assessment documenting the absence of tuberculosis within 7 days prior to the first day of work. Review of the personnel file for Employee #1, revealed that the employee's risk assessment documentation indicated that Employee #1	F 441	a 2 step TB screening has been completed. 3. The SDC or designee will in-service our HR manager about the facility policy stating that a 2-step TB screening must be completed before hire. The DON or designee will in-service clinical leadership team about the standards of the infection prevention and control program. 4. The DON or designee will monitor the infection control report for accuracy and completion each month and monthly for 3 months starting in July. All findings from audits will be reviewed at the monthly QA/QI meeting for review and further direction as appropriate	

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F 441	Continued From page 28 should have had a 2 step Tuberculosis skin test. The file only contained a 1 step tuberculosis skin test. In an interview with the Director of Nursing on 6/8/17 at approximately 10:20 AM, she stated that the employee should have had a 2 step skin test, but that the second step was not done.	F 441		