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	495270	A. BUILDING _____ B. WING _____	C 01/19/2017

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SENTARA NURSING CENTER VA BEAC	3750 SENTARA WAY VIRGINIA BEACH, VA 23452

(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 1/17/17 through 1/19/17. Three complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 116 certified bed facility was 100 at the time of the survey. The survey sample consisted of 21 residents, 17 current Resident reviews (Resident #1 through 17) and 4 closed record reviews (Resident #18 through 21).	F 000		
F 159 SS=D	FACILITY MANAGEMENT OF PERSONAL FUNDS CFR(s): 483.10(f)(10)(i)-(iv) (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not	F 159		1/28/17

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

Electronically Signed | 02/06/2017

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exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

(f)(10)(iii) Accounting and records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf.

(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(C)The individual financial record must be available to the resident through quarterly statements and upon request.

(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-
(A) When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

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F 159	Continued From page 2 (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on the Resident Group Interview, and staff interviews the facility staff failed to ensure that Resident funds were accessible 7 days a week. The Facility Staff failed to ensure that Resident Funds were accessible 7 days a week. The findings included: On 1/18/17 at 10:30 a.m. the Resident Group Interview was held in the dining room with 6 residents present. During the interview the Residents questioned why they could not get their personal funds on Saturdays and Sundays. The Residents stated they could only get money from their resident trust accounts Monday through Friday and if there was a holiday during the week their money was also unavailable. The Residents were made aware that their personal funds should be accessible to them 7 days a week. On 1/18/17 at 11:30 a.m. an interview was conducted with the Business Office Manager (BOM). The BOM was asked, "How do the Resident's access their personal funds?" The BOM stated, "they (the residents) go to the receptionist at the front desk Monday through Friday from 8:30 a.m.-5:00 p.m. to get their funds." The BOM was asked. "Do the residents get their funds from the receptionist on Saturday	F 159	F 159 Facility Management of Personal Funds 1. Business Office Manager Posted New Banking Hours for Residents to access funds 7 days per week on 1/19/17 2. All residents have the potential to be affected 3. All Managers and other business office staff were educated on availability for residents to access funds from the Patient Trust Account 4. The Business Office Manager will continue to monitor the Patient Trust Account for appropriate accounting and availability of funds 7 days per week. 5. Completion Date 1/28/17	

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and Sunday also?" The BOM stated, "No, the Business Office is closed on the weekends. The BOM was asked to show the surveyor the posted banking hours for the residents and the BOM stated, "We do not currently have banking hours posted in the facility." During this interview the Director of Clinical Services walked up and she was made aware of the Resident's concerns during the Group Interview regarding them not being able to access their personal funds on the weekends and holidays.

On 1/19/17 at 2:00 p.m. the BOM and the Regional Finance Manager provided a copy of the recently posted resident banking hours, documented in part, as follows:

BANK HOURS
Monday-Friday Business Office 10:00 AM-12:00 PM
Saturday-Sunday Rosemont Nursing Station 12:00 PM-2:00 PM

On 1/19/17 at 2:05 p.m. the Regional Finance Manager stated, "We will be making this change in all our facilities immediately."

The facility policy titled, "Resident Trust Fund-Banking Hours" dated 1/19/14 documented in part, as follows:

Policy Statement:
The facility administrator is to establish banking hours for regular trust fund activity. It has been determined from experience that if the facility has established banking hours, less time is consumed in administrating the fund and fewer errors occur. The banking hours should be posted and communicated to the residents and responsible

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F 159	Continued From page 4 parties to obtain their cooperation and be made a permanent part of the facility's policy and procedure manual. Purpose: To ensure the resident has access to funds daily. Procedures: The Business Office will provide access to the residents during normal business hours of 8:30 a.m. and 5:00 p.m., Monday through Friday, for at least two (2) hours. Saturday and Sunday access will be provided by the Nurse Supervisor for at least two (2) hours. On 1/19/17 at 4:00 p.m. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing, and the Director of Clinical Services where the above information was shared. The Director of Clinical Services was asked if the BOM had stated in her presence on 1/18/17 at 11:30 a.m. that the facilities banking hours were Monday through Friday from 8:30 a.m. to 5:00 p.m. with no weekend banking hours available, the Director of Clinical Services stated, "Yes." Prior to exit no further information was provided.	F 159		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to provide the necessary	F 253	F 253 SS=D	3/5/17

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F 253	Continued From page 5 maintenance services to maintain two resident rooms in good repair. The findings included: During the survey rooms 201 and 234 were found to have torn wall paper on the walls nearest to the head of the beds. Inside room 201 there were two areas of torn and missing wall paper; one located beneath the electrical outlet between bed A and bed B that measured 2 inches by 1 foot. The second area was located behind bed B that measured 2 inches by 3 feet. Inside room 234 there were multiple areas of ripped and torn wall paper running the entire length of the lower wall located nearest the head of the bed. The Maintenance Director escorted two inspectors to both of these rooms for inspection on 1/19/17 at 1:00 pm. He stated the torn wall paper generally occurs when the staff move the resident beds. He stated a selected number of resident rooms are inspected daily to check for general repair needs. Room 201 had been inspected earlier that morning. Review of the inspection sheet evidenced the maintenance assistant failed to note that there was torn wall paper in need of repair. The Maintenance Director stated, "He could have missed it". The above findings was shared with the Administrator, the acting Director of Nursing and the Director of Clinical Services during a pre-exit meeting conducted on 1/19/17 at 4:20 p.m. No further information was provided prior to exit.	F 253	1. Room 201 placed a wallboard behind resident bed (B) and the area between bed A and bed B another wallboard was installed. 2. Room 234 wallboard placed behind the bed refer to attached with photograh 3. Wall Defenders are being purchased for all resident rooms and these will be to the back of each bed to prevent the wall from being damaged. Contractor will be providing quote on a full resident room remodel project. 4. Maintenance Team has installed a new work order system to address any resident room issues to include wallpaper removal or repair. In addition Maintenance participates in monthly Environment of Care Rounds with Housekeeping and Administrator 5. Corrections in Place by March 5, 2017	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		3/5/17

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F 278	Continued From page 6 CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff	F 278	F278: #1 - Resident #3□s MDS with ARD	

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F 278	Continued From page 7 failed to complete each required section of a comprehensive MDS (Minimum Data Set) resident for 1 out of 21 residents (Resident #3) in the survey sample. The facility staff failed to complete the required section of Resident #3 comprehensive MDS; section C-Brief Interview for Mental Status, section D-mood and section J-pain. The findings included: Resident #3 was admitted to the facility on 05/22/15. Diagnosis for Resident #3 included but are not limited to *Vascular Dementia with behavioral disturbances, *Transient ischemic attack (TIA), *Type II Diabetes, *Epilepsy and *Depressive Disorder. *Vascular Dementia is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain (https://medlineplus.gov/ency/article/007365.htm). *TIA is a stroke lasts only a few minutes. It happens when the blood supply to part of the brain is briefly blocked (https://medlineplus.gov/ency/article/007365.htm). *Type II Diabetes is characterized by insulin resistance in appropriate hepatic glucose production, and impaired insulin secretion. Onset is usually after 40 years of age but can occur at any age (Mosby's dictionary of Medicine, Nursing & Health Professions, and 7th Edition). *Epilepsy is a group of neurologic disorders	F 278	of 04/18/16 was not fully completed. All assessments after that for this resident were fully completed. #2 - All residents have the potential to be affected by this deficient practice. #3 - The MDS Coordinator will notify the responsible discipline of any incomplete section prior to the date that MDS Coordinator is required to sign off that the MDs is complete. #4 - The Clinical Reimbursement Coordinator will audit 10% of completed assessments to verify all sections have been completed weekly for 12 weeks and report to QAPI. #5 □ March 5, 2017	

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characterized by recurrent episodes of convulsive seizures, sensory disturbances, abnormal behaviors, loss consciousness, or all of these (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

*Depressive disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

Resident #3 MDS with an ARD of 12/15/16 coded Resident #3 Brief Interview for Mental Status (BIMS) scoring a 14 of a possible 15 with no cognitive impairment. Review of Resident #3 annual MDS with Assessment Reference Date (ARD) of 04/18/16 was marked with dashes under section C-Brief Interview for Mental Status, section D-mood and section J-pain.

On 1/19/17 at 11:50 a.m., an interview with MDS Coordinator #1 regarding the dashes on Resident #3 annual MDS with ARD date 04/18/16. The surveyor asked the MDS coordinator what does the dashes mean on Resident #3 annual MDS with ARD date of 04/18/16, she replied, "The dashes marked on the MDS indicates that portion of the MDS should have been completed but wasn't".

The following section of the MDS was marked with dashes: Under Section C - C0100 - Brief Interview for Mental Status, section C0200, C0300 -Temporal Orientation (section A, B, C), section C0400, C0500, C0600, C0700, C0800, C1000, C1300, C1600 all coded with dashes. Under section D - mood, section D0100, D0200, D0300, D0500, D0600, all coded with dashes. Under section J - Health Conditions (pain

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management) to be completed regardless of current pain level, section J0100, J0200, J0300, J0400, J0500, J0600, J0700 and J0850, all coded with dashes. The MDS Coordinator stated, " All the dashes on MDS with ARD of 04/18/16 section C-Brief Interview for Mental Status, section D-mood and section J-pain should have been completed.

During an interview with Clinical Reimbursement Consultant on 1/19/17 at 1:30p.m., she stated, "Around that time in December 2016, we only had one MDS coordinator and we weren t able to finish the interviews to complete those sections of the MDS".

The facility administration was informed of the finding during a briefing on 1/19/17 at approximately 5:30 p.m. The facility did not present any further information about the findings.

Facility policy Life Care - MDS / Resident Assessment Instrument (RAI) Assessments revised 03/12/2013. Policy Statement: The assessment sections are completed by the discipline (designee).

Policy Statement: MDS / RAI are completed and remitted as required by state and federal regulations as well as according to the instruction of the most recent RAI manual. Assessments are additionally completed and provided to Resident (patient) insurance carriers as required by the carrier. The assessment sections are completed by the discipline (designee) as assigned.

Protocol for Completion of the MDS:
All assessments are coordinated by the MDS

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F 278	Continued From page 10 Coordinator There shall be an entry in the medical record note regarding completion of interview, or why the interview was unable to occur. MDS Coordinator is responsible for section C and J of the MDS. Social Worker is responsible for section D of the MDS. Exceptions: None	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 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	F 280		3/5/17

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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.

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.

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F 280	Continued From page 12 (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. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review and clinical record review the facility staff failed to involve resident in care plan meeting and to ensure that the interdisciplinary care plan were reviewed and revised as the medial status changed for 2 of 21 residents (Resident #16 and #20) in the survey sample. 1. The facility staff failed to invite Resident #16 to participate in her care plan meeting. 2. The facility staff failed to revise Resident #20's care plan with interventions after his fall. The findings included: 1. Resident #16 was admitted to the facility on 08/25/15. Diagnosis for Resident #16 included but not limited to Intracerebral Hemorrhage, Ventricular Shunt Status and Dysphagia.	F 280	F280: Resident #16 #1 - Resident #16 is her own responsible party and her plan of care has since been reviewed with Her. #2- All residents have the potential to be affected by this deficient practice. #3 - The social worker (designee) will invite residents and/or responsible parties to care plan meetings and document in the medical record when the invitation/notification is done. #4 - The MDS Coordinator (designee) will contact 10% of those scheduled for care plan meeting each week for 4 weeks then contact four per month for two months to verify the resident and/ or responsible party received	

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F 280	Continued From page 13 Resident #16 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) on 01/05/17 coded Resident #16 with no short or long term memory problems. A Brief Interview for Mental Status (BIMS) coded Resident #16 with a BIMS score 14 of a possible 15, indicating Resident #16 with no memory impairment. On 01/17/17 at 10:30 a.m., during a group meeting with 6 residents, several residents stated they were not invited to attend their care plan meeting. Care Plan Meeting: The nursing home staff will get your health information and review your health condition to prepare your care plan. You (if you're able), your family (with your permission), or someone acting on your behalf has the right to take part in planning your care with the nursing home staff (https://www.medicare.gov/what-medicare-covers/part-a/care-plan-in-nursing-home.html). An interview was conducted with Resident #16 on 1/18/17 at approximately 2:45 p.m. The surveyor asked Resident #16 was she being invited to attend her care plan meetings on a regular basis. Resident stated, "I've only been invited to one". On 1/19/17 at approximately 10:15 a.m., during an interview with the Social Worker (SW), this surveyor asked the SW the process for inviting residents to attend their care plan meeting. The SW stated, "I will get a schedule from the Minimum Data Set (MDS) Coordinator at least 3 weeks to a month in advanced before their care plan meeting is due. I will inform the resident verbally if they are alert and leave copy of the	F 280	notification, and report to QAPI. #5 □ March 5, 2017 Resident #20 #1 - The plan of care for Resident #20 was not revised to reflect post fall interventions. This Resident has been discharged. #2 - Any resident with a fall has the potential to be affected by this deficient practice. #3 - The Clinical Manager (designee) will review 24 hour report daily to identify falls and verify the associated intervention has been added to the care plan. #4 - The MDS Coordinator (designee) will review plan of care for each resident that experienced a fall to verify that the intervention was added to the plan of care for one week then review 20% weekly for three weeks, then 10% weekly for two months and report to QAPI. #5 □ March 5, 2017	

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care plan invitation letter in their room. I will also give a schedule to the unit secretary the day before or the day of the care plan meeting letting them know who is to attend and the start time of the meeting".

A Clinical Note Report dated 05/10/16 for Resident #16, stated "Facility SW and nursing reviewed the resident's chart for updating care plan and discuss any changes on 05/10/16. Nursing reported that resident has no changes. Resident code status remains Full Code is not a smoker and there are no reported behaviors. The resident will continue to remain in the building for long term care services". An Interdisciplinary Care Review sign in sheet dated for 05/10/16 list all who attended the care plan meeting, sign in sheet was without Resident #16 signature for attendance of care plan meeting.
On 1/19/17 at 10:15 a.m., the SW stated, "Resident #16 was invited to attend her care plan meeting but I don't know why she didn't come. SW was not able to produce any written documentation that Resident #16 was invited to attend her care plan meeting on 05/10/16.
An interview was conducted with the Clinical Managers (CM) from both units, Rosemont and Bayside on 1/19/17 at approximately 10:25 a.m. Both UM stated, "The unit secretary is to make sure that each nurse and Certified Nursing Assistant (CNA) knows which resident is to attend their care plan meeting and to make sure they get there on time".

During an interview with the Unit Manager (UM) on 1/19/17 at approximately 10:45 a.m., the surveyor asked, who informs you of the resident ' s care plan meeting. The UM stated, "The SW will contact me either via email or phone and will

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give me a list a week prior to the care plan meeting or sometimes the day prior to or day of the care plan meeting. I will inform the nurses and CNA's the day of care plan meeting". Surveyor asked what if a resident refuses to go to their care plan meeting, what happens then, the UM replied, "I will inform the SW and CM that the resident does not wish to attend their care plan meeting".

The facility administration was informed of the finding during a briefing on 1/19/17 at approximately 5:30 p.m. The facility did not present any further information about the findings.

The facility policy: Care planning date revised 03/11/2014. The Social Services will be responsible for notifying the family of Care Plan dates.

The facility policy: Life Care - Care Plan date revised 05/14/2013. An interdisciplinary team, in coordination with the resident, family or representative (sponsor), and physician, develops and maintains a comprehensive care plan for each resident. Resident ' s responsible parties and physicians are invited, in writing, to each appropriate care plan meeting.

2. Resident #20 was admitted to the facility on 08/03/16 and discharged to home on 09/19/16 with home health therapy services. Diagnosis for Resident #20 included but are not limited to *Dementia without behavioral disturbances, *Peripheral Vascular Disease (PVD), *Right above the Knee amputation, *Glaucoma, and *Muscle Weakness.

Resident #20 Minimum Data Set (MDS) with an

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Assessment Reference Date of 8/10/16 coded Resident # 20 Brief Interview for Mental Status (BIMS) score a 99 indicating short and long term memory problems and with moderately impaired - decision poor, cues/supervision required. In addition, the MDS coded Resident #20 requiring extensive assistance of two with transfer, bed mobility and toilet use and extensive assistance of one with dressing, hygiene and bathing.

*Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm).

*PVD is any abnormal condition that affects the blood vessels and lymphatic vessels, except those that supply the heart (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

*Amputation is the removal of a body part, either by surgery or they occur by accident or trauma to the body (https://medlineplus.gov/ency/article/007365.htm).

*Glaucoma is a group of diseases that can damage the eye's optic nerve is a leading cause of blindness. It usually happens when the fluid pressure inside the eyes slowly rises, damaging the optic nerve (https://medlineplus.gov/ency/article/007365.htm).

*Muscles weakness is reduced strength in one or

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more muscles (https://medlineplus.gov/ency/article/007365.htm).

Resident #30's clinical record nursing notes documented the following falls:
8/5/16 at 9:10 p.m., the CNA heard Resident #20 bed alarm sounding and as she entered the room she saw Resident #20 transferring from the bed to his wheelchair, lost his balance and fell to the floor. Resident #20 was assisted back to bed with two assist. An intervention for floor mats was put in place for Resident #20. Review of the care plan failed to document the revision of Resident #20 fall intervention.

According to nurse's notes on 08/06/16 at 9:14 p.m., Resident #20 with limited range of motion (ROM) to right and right shoulder. The on call doctor made aware with new orders for X-Ray of right hand and shoulder.

The X-Ray results for 08/06/16 showed osteoarthritis of the right hand but no fracture. The X-Ray results for right shoulder 1- view revealed the humerus is anteriorly and inferiorly dislocated with respect to the glenoid. There is no facture. Conclusion: Anterior shoulder dislocation.

On 08/07/16 at 1:30 p.m., Resident #20 was placed on the toilet by the nurse and CNA. Resident #20 was given his emergency call light and expresses the importance to pull the call system for assistance. Resident #20 attempted to transfer self from toilet to wheel chair, lost his balance and fell. The nurse completed her assessment with no apparent injuries noted. Review of the care plan failed to document the revision of Resident #20 fall intervention.

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According to nursing note documentation on 08/19/16 at approximately 3:50 p.m., Resident #20 was observed wheeling self-down the hallway in his w/c and at 4:10 p.m., Resident #20 was found in the bathroom on the floor by his wheelchair. The clinical manager assesses Resident #20 with complaints of pain to right shoulder. Review of the care plan failed to document the revision of Resident #20 fall intervention.

According to nurses note documentation on 08/19/16 at 7:05 p.m., a meeting was held with Resident #20 family and nursing. The family requested to have Resident #20 put into some type of restraint. Nursing staff discussed with the family that physical restraints is not an appropriate intervention because research showed that restraints poses a higher risk for injury. The nursing note also revealed that the family stated, "They understand that the facility is unable to provide 1:1 supervision 24/7 and the family had previously discussed providing supervision in shifts, and will contact other family members to make this happen".

The nursing note on 08/19/16 at 7:05 p.m. indicated that a room was offered to the family closer to the nurse's station but the family declined. Review of the care plan failed to document the revision of Resident #20 fall intervention.

On 08/19/16, Resident #20 was sent to Sentara Virginia Beach Emergency Department, an X-ray was performed revealing a right shoulder dislocation. Shoulder dislocation is caused by a forceful impact on your shoulder. This type of

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F 280	Continued From page 19 impact is from an injury, such a sport injury or a fall. A shoulder dislocation is treated by placing the humerus back in the joint. The facility administration was informed of the finding during a briefing on 1/19/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. The facility policy: Life Care - Care Plan date revised 05/14/2013. Care plans are revised as changes in the resident ' s condition dictates. Reviews are made at least quarterly. The facility policy: Life Care - Fall Prevention Program - Post Fall Protocol revision 10/04/2013. Care Plan Update: Update care plan as necessary and appropriate	F 280		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		1/31/17

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F 323	Continued From page 20 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and facility document review the facility staff failed to implement an assistive device to prevent an avoidable accident during a transfer that resulted in a fracture for one of 21 residents in the survey sample, Resident #12. The facility staff failed to implement a (Hoyer) mechanical lift device to transfer Resident #21 from the bed to a wheelchair per the resident's identified needs and plan of care. On 10/12/16 during a pivot transfer the resident's leg gave out and the resident sustained a left shoulder fracture. Hoyer lifts, or mechanical lifts, are devices used to transfer heavy or completely dependent patients. The lifts are designed to protect both patient and worker from injury during transfer. The findings included: Resident #12 was admitted to the facility on 1/7/16 with diagnosis to include a stroke with hemiplegia (paralysis on one side). The current MDS (Minimum Data Set) a significant change with an assessment reference	F 323	Past noncompliance: no plan of correction required.	

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date of 10/24/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the residents cognition was intact. The resident required assistance of two staff for bed mobility and transfers and had limited range of motion to the lower extremities. The resident was coded as having a fall with a major injury.

Review of the comprehensive plan of care dated 6/24/16 identified two problems related to falls as follows:
1. The resident was at risk for falls related to weakness, impaired mobility, incontinence, history of falls, non-ambulatory, flaccid left sided hemiparesis. The goal was that the resident would demonstrate the ability to transfer without a fall related injury. Two interventions listed were to remind the resident to call for assistance before moving from bed-to-chair and from chair-to-bed, and use Hoyer lift for transfer.
2. Patient (resident) has a history of refusing mechanical lift. The goal was that the patient will use the Hoyer lift for transfers. Interventions listed was for the staff to educate the patient (resident) on safety and importance of Hoyer lift for transfers and to transfer using Hoyer lift with two person assist for all transfers.

An initial Facility Reported Incident (FRI) was faxed to the State Survey Agency on 10/12/16 of an unusual occurrence involving Resident #12. The FRI indicated the resident was transferred by a CNA (Certified Nurse Aide) without the use of a mechanical lift. Upon transfer from the bed to the wheelchair the CNA heard a "pop" from the residents left shoulder and immediately notified a nursing staff. An X-ray was obtained and showed a sub-acute left humerus fracture (long bone in

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the arm or forelimb that runs from the shoulder to the elbow).

The FRI summary report of the facility's internal investigation and conclusion was reviewed. The resident had requested to sit on her wheelchair. The resident told the CNA, " help me stand on my good leg so I can Pivot to the chair because I hate the lift". The CNA performed the transfer manually instead of the mechanical lift, that resulted in a fracture.

On 1/18/16 at 10:40 a.m., the CNA (certified nurse aide #2) was interviewed. The CNA stated the resident had requested to be transferred from the bed to the wheelchair. The resident had refused the lift stating, "She doesn't like to use the machine at all...she has a fear of the lift...". The CNA stated she had taken care of the resident previously and was aware that if the resident refused to use the mechanical lift she was to report this to the charge nurse first. The charge nurse would then come to the room and educate the resident about the need to use the mechanical lift, at times the residents daughter would also be called to speak with the resident. The CNA stated during the pivot transfer she had placed her arms around the resident like a "bear hug", the resident lost balance, the residents left arm went up, and then she heard a "pop". The CNA stated she immediately left the room to get a nurse after placing the resident in the wheelchair. The CNA was questioned if she had access to a gait belt to be used during resident transferred, she stated, "Yes, they are kept in the staff lounge". The CNA was asked if she used the gait belt for the transfer of Resident #12, she stated, "No". The CNA stated, "I had pivoted her before without using a gait belt".

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A gait belt is a device used to transfer people from one position to another, from one thing to another or while ambulating people that have problems with balance. For example, you would use a gait belt to move a patient from a standing position to a wheelchair.

On 1/18/17 at 2:27 p.m., the staff development coordinator (SDC) was interviewed. The SDC stated, "I was coming down the hallway and saw the CNA, she looked as if she was in need of someone...she looked upset and distressed". "She asked me if I could come and take a look at the resident...I immediately looked at the resident's shoulder...the resident stated she was "okay". The SDC left to get the unit manager.

On 1/18/17 at 2:40 p.m., the Bayside unit manager was interviewed. The unit manager stated, "I was called to the room by (name of SDC), we both went to the resident's room and assessed the resident...her shoulder looked swollen...". The unit manager stated, " the CNA took matters into her own hands...the resident wanted to be transferred...the CNA shouldn't have transferred the resident...during the pivot her legs got weak...it was done incorrectly...she did cause harm".

The resident refused to go to the emergency room for evaluation. An x-ray was done at the facility and evidenced a fracture to the proximal humerus. The resident was prescribed Percocet 325 milligrams 2 tablets every 4 hours as needed for pain, a left arm sling was placed on the resident and an orthopedic appointment was made,

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F 323	Continued From page 24 On 1/17/16 at 2:30 p.m., the resident was observed sitting up in the wheelchair at the bedside. A sensor alarm was attached to the back of the wheelchair to alert staff if the resident attempted to get up unassisted. The resident stated she has lower leg pain on and off, and denied any other pain at this time. The resident stated she gets up out of bed with a "lift". During the survey days residents were observed to be transferred according to their plan of care. In response to the inappropriate transfer the facility developed a corrective action plan as follows: 1. The resident refused to go to the emergency room. X-rays were obtained. An orthopedic appointment was scheduled. The interdisciplinary team reviewed the resident's plan of care with revisions developed and implemented to address the resident's individualized needs to include pain management regiment and therapy evaluation for transfer needs. 2. Identification of all residents requiring a mechanical lift who have the potential to be affected. 3. The SDC/Designee will provide education to the nursing staff and new nursing staff regarding standards of practice for performing resident transfers. Education will include validation of skills competency for the nursing staff regarding the operation of the mechanical lift by October 25, 2016. The nursing staff will perform resident transfers in accordance with the resident's plan of care and the established standards. 4. The DON (Director of Nursing)/ Designee will review 100% of the medical records of resident's that require the utilization of a mechanical lift for transfer assistance to validate implementation of	F 323		

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F 323	Continued From page 25 appropriate measures per the residents' plan of care. The Clinical Managers will conduct staff observations of 10% of resident to validate adherence to the plan of care during transfers for four weeks then monthly for three months. Findings will be reported to the QAPI (Quality Assurance Performance Improvement) Committee for further review and recommendations. 5. Date of completion October 25, 2016. The facility met the criteria for past non-compliance for F-323 with a corrective action date of 10/25/16. The above findings was shared with the Administrator, the acting Director of Nursing and the Director of Clinical Services during a pre-exit meeting conducted on 1/19/17 at 4:20 p.m. The administrator stated there have not been any falls since 10/25/16 related to the failure to use a mechanical lift.	F 323		
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. (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.	F 371		3/5/17

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F 371	Continued From page 26 (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 observation, staff interview, and facility document review, the facility staff failed to ensure proper storage, preparation, and distribution of food in a sanitary manner. The findings included: On 1/17/17 at 12:33 pm, a Kitchen/Food Service observation was conducted with the Director of Food Services (FS). During the kitchen tour, the following findings were observed: 1. Found two (2) repackaged sliced cheese in plastic wrap in the production refrigerator and an open bag of fried okra in the walk-in freezer that were not labeled and dated. The facility policy titled "Food Production Policies and Procedures" with an original date of 4/4/92 and a review/revision date of 11/18/15, read in part, as follows, "Leftover foods are properly covered, dated, labeled, and refrigerated immediately..." 2. The walk-in freezer had food on the floor. i.e.,	F 371	F 371 F-371 Food Procure, Store/Prepare/Serve □ Sanitary 1. Education of the Dining Services staff present on the day of these observations has been completed. The expired pre-thickened milk observed to be expired was discarded during the survey rounds. 2. All residents are potentially at risk to be affected. 3. All Dining Services Staff will be educated on appropriate sanitation and food safety practices to include hand hygiene, nesting of wet pans, cleaning of coolers, use of sanitizers, appropriate label/date and monitoring and discarding of expired foods. Daily rounding and observation form has been revised to more fully incorporate issues observed. 4. The Dining Services Director or designee will review completion of rounding/observation forms daily for 2 weeks and visually inspect for expired food, label/date, hand washing,	

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F 371	Continued From page 27 peas, baby carrots, french fries and other food crumbs. The same food items were found on the same freezer floor the following day. 3. Found twenty seven (27) 8 fl. oz. boxes of (brand name) Thickened Dairy Drink 2% reduced fat milk that were expired in the dry storage area. They were labeled "Use by 12/21/16". The facility policy titled "Food Production Policies and Procedures" with an original date of 4/4/92 and a review/revision date of 11/18/15, read in part, as follows, "Dry foods are kept in the storeroom for up to one year or must be used by the recommended manufacture expiration date, whichever is first. 4. At 12:50 pm, found a washcloth soaked in a sanitizer bucket by the sink near the food preparation area. Requested the Director of Food Services to check the concentration of the sanitizing solution and it was zero (0) ppm. According to the U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration, 2005 Food Code, "(B) Cloths in use for wiping counters and other equipment surfaces shall be, (1) Held between uses in a sanitizer solution at a concentration specific under 4-501.114...(C) A quaternary ammonium compound* solution shall...(2) Have a concentration...as indicated by the manufacturer's use directions included in the labeling..." (Source: http://www.fda.gov/downloads/Food/GuidanceRegulation/ucm123980.pdf) The recommended quaternary ammonium compound concentration is 150-200 ppm (parts	F 371	cleanliness, and sanitizer use; then 2 times per week for 4 weeks. Findings will be reported to QAPI. 5. Corrections to be made by March 5, 2017	

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per million).
(Source:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMS-20055-Kitchen.pdf).

Quaternary Ammonium Compound* - any of numerous strong bases and their salts derived from ammonium by replacement of the hydrogen atoms with organic radicals and important especially as surface-active agents, disinfectants, and drugs.
(Source:
https://www.merriam-webster.com/dictionary/quaternary%20ammonium%20compound)

On 1/18/17 at 11:25 am, found 5 four-inch deep steam table pans stacked wet. The pans were wet on all surfaces. The Director of Food Services immediately removed the pans from the shelf. When asked about the facility procedure for storing the steam table pans, he stated that the staff was supposed to allow them to air dry.

According to the Food and Drug Administration Food Code 2009,
"4-901.11 Equipment and Utensils, Air-Drying Required.
Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils." (Source:
http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm189212.htm)

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The facility policy titled "Food Production Policies and Procedures" with an original date of 4/4/92 and a review/revision date of 11/18/15, read in part as follows, "All dietary equipment and utensils are cleaned, sanitized, and properly stored between use."

On 1/18/17 at 11:35 am, an observation was conducted at the tray line. Two (2) staff members failed to wash their hands properly during the meal tray preparation. Food Service staff #1 washed her hands on 5 occasions at 12:00 pm, 12:05 pm, 12:10 pm, 12:13 pm and 12:20 pm, without using paper towels to turn off the faucet. FS staff #1 turned off the faucet with her bare hands. Food Service staff #2 washed her hands for 5 seconds.

The following is the proper technique for hand washing according to the Centers for Disease Control and Prevention (CDC):
"Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them." (Source: https://www.cdc.gov/handwashing/when-how-handwashing.html)

According to the World Health Organization Hand Hygiene Technique with Soap and Water, "...Use towel to turn off faucet...). http://apps.who.int/iris/bitstream/10665/44102/1/9789241597906_eng.pdf

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F 371	Continued From page 30 On 1/19/17 at 10:20 am, Food Service (FS) staff #1 was interviewed and when asked about the proper way of hand washing, she replied, "Wash hands for 20 seconds with soap on my hands, rinse and dry". She paused and thought for a moment and stated, "Dry faucet with paper towels". On 1/19/17 at 10:25 am, the Director of Food Services was interviewed regarding his expectations for proper hand washing by staff. He stated, "Wet hands, apply soap and lather for 20 seconds, rinse and dry hands, and use paper towels to turn the faucet off". He stated that he will do an inservice for everybody on proper hand washing. The Administrator and the DON were made aware of these findings on 1/19/17, no further information was provided.	F 371		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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.	F 431		3/5/17

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F 431	Continued From page 31 (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 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:	F 431		

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F 431	Continued From page 32 Based on observation, staff interviews, clinical record review and during the course of a complaint investigation the facility staff failed to ensure an effective system was in place to identify and prevent diversion or loss of scheduled II controlled drugs for 1 of 21 residents in the survey sample, Resident #21. Failed to ensure staff nurses were aware of the location of a key to the storage box for controlled substances and failed to reconcile and remove controlled drugs for a discharged resident. *Scheduled II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. www.DEA (Drug Enforcement Administration).gov 1. A diversion/ loss of sixty 20 milligram oxycodone capsules dispensed for Resident #21 occurred on the Rosemont unit sometime between day of receipt on Tuesday, April 12, 2016 through discovery of loss on Sunday, April 17, 2016. Oxycodone is a scheduled II controlled drug. 2. The facility staff failed to ensure the facility's staff nurses for the Rosemont unit were aware of the location of the key to the controlled substance refrigerator locked box and the facility's staff failed to ensure that controlled substances in the refrigerator locked box were reconciled by the oncoming and outgoing licensed nurses. 3. The facility staff failed to ensure a discharged resident's controlled medication were removed from the refrigerator narcotic locked box.	F 431	F431 #1 - The missing controlled medication for Resident #21 has been investigated and reported to appropriate agencies. Controlled medications for discharged residents were removed from the refrigerator locked box and the prescription forms are removed from the cart. #2 - Any resident requiring controlled medication is at risk to be affected by this deficient practice. #3 - All facility staff nurses will be educated by the SDC (designee) on the location of the key to the storage box for controlled substances and on policies pertaining to reconciliation of controlled medications at change of shift, removal of controlled medications for discharged residents, and storage of practitioner prescription forms. #4 - The Clinical Manager (designee) will verify daily that one nurse knows location of the storage box key for a week then three nurses weekly for seven weeks. The Clinical Manager (designee) will verify that reconciliation of controlled medications occurs at each shift change, that medications for discharged residents are promptly removed daily and that there are no prescription forms with DEA numbers or provider	

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F 431	Continued From page 33 The findings included: 1. An initial Facility Reported Incident (FRI) was faxed to the State Survey Agency on 4/19/16. The FRI was of an ongoing internal investigation of an unusual occurrence involving the diversion of the prescribed medication oxycodone. A FRI summary of the ongoing investigation was received at the State Survey Agency on 4/28/16. The investigation found the following: 1. Sixty oxycodone capsules were discovered missing Sunday, April 17, 2016 involving medications that were ordered from the pharmacy on April 12, 2016; dispensed for Resident #21. 2. Safety stand downs were conducted at all affiliated senior care sites within the organization on Monday, April 18. 2016. No other drug discrepancies were found. Resident #21 was admitted to the facility on 3/30/16 and discharged home on 5/2/16. The resident's diagnosis included sepsis and intravenous antibiotics treatments were administered during the course of the stay. The resident also was administered oxycodone 20 milligrams one every 4 hours as needed for pain management. The admission MDS (Minimum Data Set) with an assessment reference date of 4/6/16 the coding on the Brief Interview for Mental Status was incomplete with dashes. The resident was coded as having pain and recieving PRN (as needed) pain medication. Investigation of the prescribing and receiving of	F 431	name stored on medication carts for one week then 3 times weekly for two weeks and weekly thereafter for two months and report to QAPI. #5 - March 5, 2017.	

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the oxycodone 20 milligrams capsules and staff written statements evidenced the following:
1. On 4/1/16 the nurse practitioner prescribed#60 capsules of oxycodone 20 milligrams. The capsules were dispensed and received on 4/1/16.
2. A second prescription for #120 oxycodone capsules was prescribed on Tuesday, 4/12/16. The pharmacy dispensed only #60. These were received by the night Registered Nurse Supervisor #8 on 4/12/16 per her written statement and signature on the pharmacy delivery form. The RN night supervisor then hand delivered these drugs to LPN #7 night nurse. LPN #7 placed the #60 capsules inside one of the medication carts that did not contain medications for Resident #21's room. The RN supervisor wrote in her statement that she later observed LPN#7 remove the #60 oxycodone and place them inside the correct medication cart.
3. On Thursday, 4/14/16 the day shift nurse (Licensed Practical nurse #4) identified the resident had only #10 capsules of oxycodone remaining and requested from the nurse practitioner a prescription for an additional #40 capsules. The pharmacy label directed the staff to reorder 3 business days ahead.
4. On Sunday, 4/17/16 according to the night shift nurse (LPN#7) written statement she had called the pharmacy for a follow up on the refill of the oxycodone. The nurse was informed that they could not refill the prescription as a recent delivery had been done on 4/12/16. A search for the #60 oxycodone and the corresponding Controlled Medication Usage sheet was conducted; both were found missing.

In response the Director of Nursing and pharmacy were notified on Monday, 4/18/16. Pharmacy began a review of the drug prescription

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and orders. The facility informed the appropriate State Agencies to include the State Survey Agency and DEA. Of the five nurses who worked on those days after the delivery of the #60 oxycodone, none were drug tested. One nurse who had not worked on Tuesday 4/13/16 or Wednesday 4/14/16
was suspended and drug tested; the results were negative.

Further investigation evidenced the facility staff were not consistently counting the narcotics at the end of shifts as the Change of Shift Drug Control Records had multiple blanks entries that were not signed on the Rosemont unit. Also, found stored inside one of the narcotic count books kept on a medication cart on the Rosemont unit were prescription forms with the practitioners group individual names and DEA numbers. According to acting DON #3, these prescription forms were no longer in use, new forms were implemented as of 10/15/16 that did not include the pre-printed DEA numbers.

The Policy titled Job Aid: Life Care-Medications-Controlled Substances dated 2/16/1999 reads: Drugs listed in schedules II, III and IV, shall be subject to special handling, storage, disposal and record keeping.
Procedure: 11. At the change of shift, the licensed nurse coming on duty, and the licensed nurse going off duty, shall follow this procedure:
1. The licensed nurse going off duty uses the single dose/shift count sheet and reports the quantity of the drug remaining.
2. The licensed nurse coming on duty verifies the actual quantity of drug remaining.
3. The quantity remaining is entered on the single dose/shift count sheet.

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F 431	Continued From page 36 4. If there is a discrepancy, the Medication Record is reviewed. 5. If the discrepancy cannot be resolved, the Director of Nursing in contacted. The above findings was shared with the Administrator, the acting Director of Nursing (DON) and the Director of Clinical Services during a pre-exit meeting conducted on 1/19/17 at 4:20 p.m. The Director of Clinical Services stated it is not their practice to have the DEA numbers out on the units; they are to be secured and accessible to only the practitioners. No further information was provided prior to exit. COMPLAINT DEFICIENCY The finding included: On 1/18/17 at approximately 11:50 a.m., during inspection of the medication refrigerator on the (name of unit) the key to the controlled substance locked box could not be located. Licensed Practical Nurse (LPN) #4 tried 4 sets of keys but neither set included the key to open the	F 431		

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refrigerated controlled substances locked box. The sets of keys included the keys of the nurses administering medication on the shift at that time. LPN #4 and Registered Nurse (RN) #4 stated there were no medications in the refrigerated controlled substances locked box therefore; there was no need to open it. At approximately 12:10 p.m., Clinical Manager #2 came to the unit and informed the nursing staff the key to the refrigerated controlled substances locked box was inside the emergency medication cart.

LPN # 3 obtained the refrigerated narcotic box key from the emergency medication cart and the controlled substances locked box was opened and inspected. Inside the refrigerated controlled substances locked box LPN #3 removed a clear plastic medication bag containing 3 unopened 1 millimeter vials of Lorazepam and 1 opened 1 milliliter vial of Lorazepam with approximately 0.25 milliliters in the vial. The Lorazepam label was dated 11/14/16 and the manufacturer's expiration date was 11/13/17. The refrigerated controlled substances locked box usage/count sheet last entry was dated 12/6/16 and it stated there were only 3 vials in the box.

LPN #3 also obtained a 30 milliliter vial of Lorazepam from the refrigerated controlled substances locked box. It had never been opened and the resident it was prescribed for was discharged from the facility 3/1/16. There was no controlled medication usage/count sheet in the narcotic count book but there was one in the refrigerated narcotic book with the medication.

Lorazepam is a scheduled IV controlled medication with a potential for abuse or diversion. It is prescribed to slow activity in the brain to allow

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for relaxation.

LPN #3 was asked if the medications in the refrigerated controlled substances locked box had been reconciled at the beginning of the her shift. LPN #3 stated she did not reconcile them but there was a possibility the nurse on the other medication cart had reconciled the medications. LPN #3 stated she had not been told prior to 1/18/17 the key to the refrigerated controlled substances locked box was in the emergency medication cart.
LPN #25 also stated she was unaware there were medications in the refrigerated controlled substances locked box in the refrigerator and that there was a key to the refrigerated controlled substances locked box in the emergency medication cart. She had not reconciled the medications in the refrigerated narcotic box on 1/18/17.

RN #5 identified herself as a house supervisor. RN #5 was asked, what is the facility's procedure for managing the key to to the refrigerated controlled substances locked box and discharge resident medications? RN #5 stated she was unaware the refrigerated controlled substances locked box is kept on the emergency medication cart. RN #5 also stated discharge resident medications are to be removed from service by the licensed nurse and given to the Clinical Manager. The 2 nurses reconcile the medications and sign together after verifying what was removed from service. The Clinical Manager along with another licensed nurse or the Director of Nursing destroys the medications.

The Administrator, acting Director of Nursing and Corporate Director of Clinical Operations were

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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 431	Continued From page 39 briefed of the above information on 1/19/17 at approximately 6:00 p.m. The acting Director of Nursing stated the oncoming and outgoing licensed nurses should count all controlled medication on the medication cart and in the refrigerated controlled substances locked box prior to signing the narcotic control book which verifies the narcotic medications count has been verified by both licensed nurses. The Facility's policy titled; Medication Controlled Substance Policy with a revision date of 6/23/16 stated under purpose, that drugs listed in scheduled II, III, and IV, shall be subject to special handling, storage, disposal and recordkeeping. Under Procedure 7; the policy stated the charge nurse/medication nurse maintains the keys to the controlled drug storage areas. Under Procedure 11; the policy stated the licensed nurse going off duty uses the single dose/shift count sheet and reports the quantity of the drug remaining. The licensed nurse coming on duty verifies the actual quantity of drug remaining. The quantity remaining is entered on the single dose sheet. Both nurses sign the sheet.	F 431		
F 441 SS=E	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 and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting,	F 441		3/5/17

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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.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct

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F 441	Continued From page 41 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: 2. The facility staff failed to implement appropriate infection control practices to prevent the potential for cross contamination and infection. The nurse failed to discard a single use opened package of Aquacel Ag Extra 4 in. x 5 in. wound dressing. Instead, the nurse placed it back inside the treatment cart for further use for Resident #7. Resident #7 was admitted to the facility on 10/3/15 and readmitted on 7/13/16. Diagnosis included a chronic stage III pressure ulcer (full thickness tissue loss) to the right buttock. The quarterly MDS (Minimum Data Set) with an Assessment Reference Date of 11/11/16 coded the resident as having long and short term memory deficits with severely impaired cognition. The resident was receiving treatments to the	F 441	F441 Dressings: #1 - A new dressing is opened each time Resident #7 receives treatment to his wound. #2 - All residents requiring wound care are at risk for this deficient practice. #3 - SDC (designee) will educate all nurses on standards of use for sterile dressings and commonly used device symbols printed on packaging of dressings such as do not reuse, single use, or use only once. #4 - Clinical Manager (designee) will check dressing carts weekly for one month then every two weeks for two months to ensure opened dressings are not saved; will verify with two nurses	

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F 441	Continued From page 42 pressure ulcer every three days and an antibiotic Cipro 250 milligrams twice a day for chronic leukocytosis (elevated white blood count) associated from the pressure ulcer. An observation of the right buttock dressing change was conducted on 1/17/17 at 6:30 p.m. After cleaning the wound bed Licensed Practical Nurse (LPN#5) cut a small piece of the Aquacel Ag Extra 4 in. x 5 in. wound dressing and packed it into the wound. The wound was approximately the size of a quarter. The wound was then covered by another dressing. After the dressing change the nurse placed the opened single use package of Aquacel Ag back into a plastic bag with other supplies designated for Resident #17, to include a spray bottle of Dermal Wound Cleanser and an opened bundle pack of 4 x 4 gauze. The plastic bag was then placed back into the treatment cart for further use. On 1/18/17 at 1:40 p.m., the nurse (LPN#6) assigned to Resident #17 accompanied this inspector inside the storage room where the treatment carts were located. The bag containing Resident #17's dressing supplies was stored inside the cart, the opened single use Aquacel Ag dressing was in the bag. The nurse was asked if she would use this same dressing on the resident, she stated, "Yes, I would use this dressing". On 1/18/17 at approximately 5:30 p.m., LPN #5 was approached by this inspector. Next to LPN#5 was the Registered Nurse Supervisor #7, both were asked if the Aquacel Ag dressing was for single use or multiple use. Both stated it could be used multiple times. LPN#5 stated she would place the unused dressing back for reuse so that	F 441	per shift weekly for one month then every two weeks for two months and report to QAPI. #5 □ March 5, 2017 Tracking & Trending #1 - The Clinical Managers will be educated on the necessity to complete all areas on infection control tracking documents, document impromptu education that includes a sign in sheet, and the importance of organism identification as it relates to trending infections. #2 - All residents are at risk to be affected by this deficient practice. #3 - SDC (designee) will educate all nurses on the necessity to complete all areas on infection control tracking documents, document impromptu education that includes a sign in sheet, and the importance of organism identification as it relates to trending infections. #4 - The Clinical Managers (designee) (on a unit other than their own) will verify monthly for three months the completeness of infection control tracking documents including organism identification as appropriate and that there is appropriate documentation of impromptu education and report to QAPI. #5 - March 5, 2017	

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the whole dressing "does not go to waste...I assume they are expensive". The RN Supervisor stated, "As far as I know they can be used multiple times as long as they are not contaminated". The dressing package was presented for review of the commonly used medical device symbols printed on the package. Both were unaware of the symbol for "do not re-use, single use, or use only once" that was printed on the package (a 2 inside a do not sign).

The above findings was shared with the Administrator, the acting Director of Nursing and the Director of Clinical Services during a pre-exit meeting conducted on 1/19/17 at 4:20 p.m.

No further information was provided prior to exit.

Based on review of the facilities infection control program, staff interviews and review of the facility's policy the facility's staff failed to establish an infection control program which investigates, controls, and prevent the onset and the spread of infections.

The findings included:

An interview was conducted with the facility's two Clinical Nurse Managers on 01/19/17 at

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approximately 12:15 p.m., to review the facility's Infection Control Program. The Clinical Nurse Managers stated their processes consisted of use of infection control surveillance forms to track all infections including residents admitted from the community. The surveillance form was to identify the location of the resident with the infection, signs and symptoms exhibited by the resident, the organism identified, what the culture and sensitivity results revealed, the approximate date the infection was acquired, the name/date antibiotic therapy was initiated and nursing interventions.

The columns for signs and symptoms exhibited by the resident, the organism identified, and what the culture and sensitivity results revealed were not completed.

The Clinical Nurse Managers stated the data was not combined to reflect the facility totally; it was divided by units. The Clinical Nurse Managers stated they review their individual units and the information attained is supposed to be beneficial in determining trends such as; cross-contamination, hand washing practices, use of gloves, gowns, masks, and proper hygiene of the incontinent resident. The Clinical Nurse Managers stated they provide impromptu in-servicing to staff if trends are identified. Neither Clinical Nurse Manager had documentation of any impromptu in-services.

The Clinical Nurse Managers chose to review the infections for December 2016 to demonstrate the facility's infection control process and benefit of surveillance tracking. The review revealed one

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unit had nine residents who were prescribed antibiotics for infections and one resident was receiving a prophylactic antibiotic. Two of the nine residents were treated for urinary tract infections, two other residents were treated for pneumonia, two additional residents were treated for sepsis (site unidentified), one of the nine was treated for osteomyelitis, one of the nine residents was treated for clostridium difficile and one of the nine residents infection was unidentified. Only two of the nine residents receiving antibiotic therapy bacterial organism was identified.

The other unit had 2 residents on antibiotic therapy in December 2016. One resident was treated for pneumonia and the other resident was treated for clostridium difficile. The resident with pneumonia, bacterial organism was not documented.

Clostridium difficile is a bacterium that can causes symptoms ranging from diarrhea to life-threatening inflammation of the colon. Clostridium difficile most commonly affects older adults in hospitals or in long-term care facilities and typically occurs after use of antibiotic medications.

Osteomyelitis is infection and inflammation of the bone and bone marrow.

A urinary tract infection is an infection of the body's drainage system for removing wastes and extra water. The urinary tract includes two kidneys, two ureters, a bladder and a urethra.

Pneumonia is an inflammatory condition of the lung.

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Sepsis is a life-threatening illness caused by your body ' s response to an infection.

The Clinical Nurse Managers each had color coded floor plans of the rooms of their respective units which identified the type of infection; pneumonia, urinary tract infection, clostridium difficile, etc, but the types of bacterial organisms were not identified. Therefore they had no information to determine trends.

The Clinical Nurse Managers stated knowing the causative organism is important for identifying trends, preventing outbreaks, and improving facility practices and developing in-services plans. The Clinical Nurse Managers stated they would review the individual laboratory report separately to obtain the information on the organism and would ensure all necessary data was obtained so they could confirming and manage infections.

The Clinical Nurse Managers stated all staff is in-serviced on the importance of hand washing and random undocumented assessments and education is provided on handwashing. The Clinical Nurse Managers also stated direct care staff members receives ongoing education regarding handling soiled and clean linens, incontinence care, care of indwelling catheters, isolation precautions and use of personal protective equipment.

The Clinical Nurse Managers stated they each reported how many types (urinary tract, pneumonia, etc,) of infections were treated in the last Quality Assurance meeting. They both stated there was not enough information on the surveillance form to identify trends, clusters, the

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F 441	Continued From page 47 need for additional education, etc,. The Administrator, acting Director of Nursing and Corporate Director of Clinical Operations were briefed of the above information on 1/19/17 at approximately 6:00 p.m. The acting Director of Nursing stated infections are reviewed and discussed daily and the infection control surveillance report is a tool used to identify trends. The Facility's Infection Control policy with a revision date of 1/14/14 stated the primary purpose of the Infection Control Policies and Procedure is to establish guidelines to follow for preventing transmission of infectious or communicable diseases and to control nonsocominal infections.	F 441		