STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING ______ B. WING ______	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	**827 NORVIEW AVENUE NORFOLK, VA 23509**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/15/18 through 5/17/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least	E 004		6/25/18

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

Electronically Signed — 06/21/2018

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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E 004	Continued From page 1 annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to conduct a risk assessment of identified hazards. The findings included: During an interview on 5/17/18 at 10:40 A.M. with the administrator, Quality Assurance Coordinator and the Maintenance Director, were asked if the facility had conducted a risk assessment of it's emergency preparedness program that will assist the facility in addressing the needs of their patient population. The administrator stated, "No" the facility had not conducted an assessment nor had it consider hazards specific to the location of the facility. The facility was noted to located next to a rail road crossing and a river was located approximately 200 feet in the rear area of the facility. The facility staff failed to conduct a risk assessment of identified hazards.	E 004	Disclaimer Notice: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but instead is prepared for the sole purpose of compliance with State and Federal Regulations. E004 1. The Licensed Nursing Home Administrator (LNHA) and interdisciplinary team provided a copy of the Hazard Vulnerability to the survey team. The LNHA and Maintenance Director will review and re perform the Hazard Vulnerability Assessment on 6-8-18. 2. All Residents have the potential to be affected. The Licensed Nursing Home Administrator (LNHA) and interdisciplinary team provided a copy of the Hazard Vulnerability to the survey team. The LNHA and Maintenance Director will review and re perform the Hazard Vulnerability Assessment on 6-8-18. 3. The Hazard Vulnerability Assessment and the facility□s emergency preparedness plan enhancements in response to identified vulnerabilities will be reviewed in the Quality Assessment and Assurance (QAA) committee on 6-20-18. Following this review, recommendations, and/or further enhancements, the Hazard Vulnerability	

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E 004	Continued From page 2	E 004	Assessment will replace the previous Hazard Vulnerability Assessment currently included in the facility□s Emergency Preparedness Manuals. This assessment will be re performed at least annually and post event when the facility□s responsive action is tested. All staff, full time (FT), part time (PT) and per diem (PD) will be educated to the Hazard Vulnerability Assessment and the facility□s responsive emergency preparedness plan by the NHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff. 4. The LNHA is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The LNHA will conduct a Hazard Vulnerability Assessment at least annually; ensuring a the development and/or enhancement of an emergency preparedness plan designed to address facility vulnerabilities ; b) The QAA committee will review the Hazard Vulnerability Assessment tool and responsive emergency preparedness plan quarterly x one (1) year and then annually thereafter; ensuring a comprehensive emergency preparedness approach. Findings will be addressed promptly with re-education as required.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop	E 007		6/25/18

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E 007	Continued From page 3 and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to identify the facilities patient population at risk at risk during an emergency. As well as what strategies the facility has put in place. The findings included: During an interview on 5/17/18 at 10:43 a.m. with the administrator, Quality Assurance Coordinator and the Maintenance Director, they were asked for the identity of the at risk patients in the facility. The facility did not have a specific identification and vulnerabilities of patients at risk. When asked for strategies that the facility had in place to address the at risk residents, the administrator stated, they did not have any strategies. The emergency plan also, failed to identify what types of services the facility would be able to provide in an emergency. The facility staff failed to identify patients population at risk and strategies to provide	E 007	E007 1. The LNHA and Maintenance Director have re performed the Hazard Vulnerability Assessment ensuring identification of persons at-risk, the types of services the facility will be able to provide in an emergency and the continuity of operations. In response, the facility will enhance its emergency preparedness plan, as needed. 2. All Residents have the potential to be affected. The LNHA and Maintenance Director have completed the Hazard Vulnerability Assessment which addresses persons at-risk, the types of services the facility will be able to provide in an emergency and the continuity of operations. In response, the facility will enhance its emergency preparedness plan, as needed. 3. The Hazard Vulnerability Assessment	

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E 007	Continued From page 4 services in an emergency.	E 007	and the facilitys responsive emergency preparedness plan for residents at-risk along with the services the facility will be able to provide during emergencies along with the continuity of services available will be reviewed by the QAA committee on Following this review, recommendations, and/or further enhancements, will replace the previous Hazard Vulnerability Assessment currently included in the facilitys Emergency Preparedness Manuals. This assessment will be re performed at least annually or post event where in the assessment and facilitys responsive action is tested. All staff, full time (FT), part time (PT) and per diem (PD) will be educated to the Hazard Vulnerability Assessment and the facilitys responsive plan to identified vulnerabilities by the LNHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The LNHA will conduct a Hazard Vulnerability Assessment at least annually; ensuring a the development/enhancement of an emergency preparedness plan designed to address facility vulnerabilities ; b) The QAA committee will review the Hazard Vulnerability Assessment tool and responsive emergency preparedness plan quarterly x one (1) year and then annually thereafter; ensuring a comprehensive	

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E 007	Continued From page 5	E 007	emergency preparedness approach. Findings will be addressed promptly with re-education as required.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:	E 015		6/25/18

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E 015	Continued From page 6 (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the Emergency Preparedness Plan included a fire watch process and have procedures and contracts to provide sewage and waste disposal. The findings included: During an interview on 05/17/18 at 10:52 A.M. with the administrator, Quality Assurance Coordinator and the Maintenance Director, the administrator was asked for documentation of the facilities Fire Watch Process. The administrator stated, the facility did not have documentation of a Fire Watch Process. The administrator was asked for procedures and contracts for sewage and waste disposal during an emergency. The administrator stated, the facility did not have contracts or procedures for sewage and waste disposal during an emergency. The facility staff failed to have documentation that	E 015	E015 1. The LNHA provided a copy of the Fire Watch policy as well as the Fire Watch procedure to the surveyors. A review of the facility□s Emergency Preparedness Plan confirms the presence of both the policy and procedure. The facility will contract with a portable waste management contractors for alternate means of managing waste and sewage during an emergency. The facility has also reviewed and enhanced its□ Toilet Use during Emergencies policy should the portable waste management contractor be unable or delayed in service to the facility during emergencies. 2. All Residents have the potential to be affected. The LNHA provided a copy of the Fire Watch policy as well as the Fire Watch procedure to the surveyors. A review of the facility□s Emergency	

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E 015	Continued From page 7 the emergency preparedness plan included a fire watch process and contracts to provide sewage and waste disposal during an emergency.	E 015	Preparedness Plan confirms the presence of both the policy and procedure. The facility will contract with a portable waste management contractors for alternate means of managing waste and sewage during an emergency. The facility has also reviewed and enhanced its Toilet Use during Emergencies policy should the portable waste management contractor be unable or delayed in service to the facility during emergencies. 3. The Fire Watch Policy, Fire Watch Procedure and Toilet Use during Emergencies policy will be reviewed in the QAA committee on 6-20-18. The portable waste management contracts for alternate means of waste management during emergencies will also be reviewed by the QAA committee on 6-20-18. Following this review, recommendations, and/or further enhancements, these policies, procedure and contracts will replace previous copies of the same in the facility's Emergency Preparedness Manuals. All staff, full time (FT), part time (PT) and per diem (PD) will be educated to the facility's Fire Watch policy and procedure as well as the Toilet use during an emergencies policies. A Formalized Agreement and Contingency: listing (a form which includes emergency contact information of contract services) will be updated by the LNHA routinely. Emergency preparedness education shall occur at least annually with all staff. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator	

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E 015	Continued From page 8	E 015	and committee as noted below will be responsible for the ongoing monitoring of this process as follows: a) The LNHA will conduct a quarterly review of the Fire Watch policy and procedure as well as the completed Formalized Agreement & Contingencies checklist will occur for one (1) year; ensuring the provision of provisions for emergency use. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan; b) The QAA committee will review the Formalized Agreement & Contingencies checklist semi-annually for one (1) year and then annually thereafter. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan.	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and	E 018		6/25/18

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E 018	Continued From page 9	E 018		

location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

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E 018	Continued From page 10 *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to train staff on the facility's Emergency Preparedness Plan. The findings included: During an interview on 5/17/18 at 11:58 A.M. with the administrator, Quality Assurance Coordinator and the Maintenance Director, the administrator was asked for documentation that facility had trained staff on the Emergency Preparedness Tracking System. When asked for documentation that staff had been trained on the facilities tracking system during an emergency, the administrator stated, the facility had not trained staff on the Emergency Preparedness Tracking System. The facility staff failed failed to train staff on the emergency preparedness tracking system.	E 018	E018 1. A review of the facility□s Emergency Preparedness Plan confirms the presence of a Resident Evacuation Tracking Form and the Evacuations Consideration policy. The LNHA will ensure the Resident Evacuation Tracking Form includes names of all current residents. The LNHA will be responsible for reeducating all staff to the Resident Evacuation Tracking Form, its□ purpose, and the Evacuation Policy by 6-25-18. 2. All Residents and Staff have the potential to be affected. A review of the facility□s Emergency Preparedness Plan confirms the presence of a Resident Evacuation Tracking Form and the Evacuations Consideration policy. The LNHA will ensure the Resident Evacuation Tracking Form includes names of all current residents. The LNHA will be responsible for reeducating all staff to the Resident Evacuation Tracking Form, its□	

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E 018	Continued From page 11	E 018	purpose, and the Evacuation Policy by 6-25-18. 3. The Resident Evacuation Tracking Form will be reviewed in the QAA committee meeting on 6-20-18. Following this review, recommendations, and/or further enhancements, this policy and form will replace those previously included in the Emergency Preparedness Manuals. The HR Director will ensure that all newly hired staff are added to the Evacuations Consideration and tracking form; as they learn about the facility□s emergency plan. All staff, full time (FT), part time (PT) and per diem (PD) will be educated to the facility□s Emergency Personnel Roster and tracking tool by the NHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) A quarterly review of the Resident Evacuation Tracking Form and policy will be conducted by the LNHA; occurring for one (1) year; ensuring the inclusion of all current residents. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan; b) The QAA committee will review the Resident Evacuation Tracking Form semi-annually for one (1) year and then annually thereafter. This review shall also be	

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E 018	Continued From page 12	E 018	conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan.	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have policy and procedures for volunteers who remain in the facility during sheltering in place.	E 022	E022 1. A review of the facility□s Emergency Preparedness Plan was conducted; confirming the presence of a policies regarding Use of Volunteers during an	6/25/18

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E 022	Continued From page 13 The findings included: During an interview on 5/17/18 at 12:07 P.M. with the administrator, Quality Assurance Coordinator, and the Maintenance Director, the administrator was asked if the facility had a policy for volunteers who remain in the facility during sheltering in place. The administrator, stated, the facility did not have a policy for volunteers who remain in the facility during an emergency. The facility staff failed to policy and procedures for volunteers who remain in the facility while sheltering in place.	E 022	Emergency as well as a Sheltering in Place policy which is applied to all persons (including Volunteers) in the facility at the time of the emergency or drill. 2. All Volunteers have the potential to be affected. A review of the facility□s Emergency Preparedness Plan was conducted; confirming the presence of a policies regarding Use of Volunteers during an Emergency as well as a Sheltering in Place policy which is applied to all persons (including Volunteers) in the facility at the time of the emergency or drill. 3. The Use of Volunteers during an Emergency and the Sheltering in Place policies will be reviewed by the QAA committee on 6-20-18. Following this review, recommendations, and/or further enhancements, these policies will replace those previously included in facility□s Emergency Preparedness Manuals. The Human Resources (HR) Director or LNHA will ensure that all volunteers are added to the Emergency Personnel Roster during orientation. All staff, full time (FT), part time (PT) and per diem (PD) and volunteers will be educated to the facility□s Use of Volunteers during an Emergency and Sheltering in Place policies by the LNHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator	

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E 022	Continued From page 14	E 022	and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) A Quarterly review the Emergency Personnel/Volunteer Roster and tracking tool by the LNHA will occur for one (1) year; ensuring the inclusion of all current volunteers. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan; b) the QAA committee will review the Emergency Personnel Roster semi-annually for one (1) year and then annually thereafter. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		6/25/18

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E 024	Continued From page 15 *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to develop emergency preparedness policies and procedures, based on the emergency plan for the use of volunteers in an emergency. The findings included: During an interview on 5/17/18 at 12:16 P.M. with the administrator, Quality Assurance Coordinator, and the Maintenance Director, the administrator was asked for a policy for the use of volunteers in an emergency. The administrator stated, the facility did not have a policy for the use of volunteers. The facility staff failed to policy and procedures for volunteers in an emergency.	E 024	E024 1. A review of the facility□s Emergency Preparedness Plan was conducted; confirming the presence of a policy regarding Use of Volunteers during an Emergency. 2. All Volunteers have the potential to be affected. A review of the facility□s Emergency Preparedness Plan was conducted; confirming the presence of a policy regarding Use of Volunteers during an Emergency. 3. The Use of Volunteers during an Emergency policy will be reviewed by the QAA committee on 6-20-18. Following this review, recommendations, and/or further enhancements, this policy will replace those previously included in the facility□s Emergency Preparedness Manuals. The Human Resources (HR) Director or LNHA will ensure that all volunteers are added to the Emergency Personnel Roster during orientation. All staff, full time (FT), part time (PT) and per diem (PD) and volunteers will be educated to the facility□s Use of Volunteers during an Emergency policy by the LNHA by 6-25 -18. Emergency preparedness education shall occur at least annually	

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E 024	Continued From page 16	E 024	with all staff. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) A quarterly review the Emergency Personnel/Volunteer Roster and tracking tool by the LNHA will occur for one (1) year; ensuring the inclusion of all current volunteers. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan; b) the QAA committee will review the Emergency Personnel Roster semi-annually for one (1) year and then annually thereafter. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary,	E 026		6/25/18

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E 026

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in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility staff failed to have policy and procedures for the facility's staff role in providing care and treatment at alternate care sites.

The findings included:

During an interview on 5/17/18 at 12:22 P.M. with the administrator, Quality Assurance Coordinator and the Maintenance Director the administrator was asked what role did staff have in providing care at alternate care sites during emergencies. The administrator stated the facility did not have policy and procedures addressing the facility staffs role in providing care at alternate care sites.

The facility staff failed to have policy and procedures for the facility staffs role in providing care treatment at alternate care sites.

E 026

E026
1. A review of the facility□s Emergency Preparedness Plan was conducted; confirming the presence of a policy regarding Evacuation Procedure Planned Evacuation which addresses the provision of staff to alternate site post evacuation as needed.

2. All Residents and staff have the potential to be affected. A review of the facility□s Emergency Preparedness Plan was conducted; confirming the presence of a policy regarding Evacuation Procedure Planned Evacuation which addresses the provision of staff to alternate site post evacuation as needed.

3. The Evacuation Procedure Planned Evacuation policy will be reviewed by the QAA committee on 6-20-18. Following this review, recommendations, and/or further enhancements, this policy will replace those previously included in the facility□s Emergency Preparedness Manuals. The Human Resources (HR)

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E 026	Continued From page 18	E 026	Director or LNHA will ensure that all staff are alerted to their roles which may include alternate site care assignments post evacuation. All staff, full time (FT), part time (PT) and per diem (PD) will be educated to the facility□s Evacuation Procedure Planned Evacuation policy by the LNHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) A quarterly review the Emergency Personnel/Volunteer Roster and tracking tool by the LNHA will occur for one (1) year; ensuring all personnel and volunteer names are listed. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan; b) The QAA committee will review the Emergency Personnel Roster semi-annually for one (1) year and then annually thereafter. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and	E 035		6/25/18

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E 035	Continued From page 19 updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to share information of the emergency preparedness plan with all residents. The findings included: During an interview on 5/17/18 at 12:34 P.M. with the administrator, Quality Assurance Coordinator, and Maintenance Director, the administrator was asked how all residents of the facility were made aware of the emergency preparedness plan. The administrator stated residents who attended Resident Council were informed. When asked how other residents who might not attend Resident Council received information of the emergency preparedness plan, the administrator stated, all other residents have not been made aware. The facility staff failed to share information of the emergency preparedness plan with all residents.	E 035	E035 1. The LNHA has developed a facility Emergency Preparedness Summary Sheet for all residents and visitors. Each current resident has been provided a summary sheet along with a verbal synopsis of the same. This Emergency Preparedness summary sheet will be added to the admission process; ensuring that all residents upon admission learn of the facility□s Emergency Preparedness synopsis. This Emergency Preparedness Summary Sheet will be reviewed with residents/responsible parties annually thereafter. 2. All residents have the potential to be affected. The LNHA has developed a facility Emergency Preparedness summary sheet for all residents and visitors. Each current resident has been provided a summary sheet along with a verbal synopsis of the same. This Emergency Preparedness Summary Sheet will be added to the admission process; ensuring that all residents upon admission learn of the facility□s Emergency Preparedness synopsis. This Emergency Preparedness summary sheet will be reviewed with	

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E 035	Continued From page 20	E 035	residents/responsible parties annually thereafter. 3. The Emergency Preparedness Summary Sheet for residents will be reviewed in the QAA committee on 6-20-18. Following this review, recommendations, and/or further enhancements, this Emergency Preparedness Summary Sheet will become a component of the facility□s Emergency Preparedness Manuals. The Admissions Coordinator/Social Services Coordinator will review the Emergency Preparedness Summary Sheet with the resident/responsible party during the admission process with residents/responsible parties. All staff, full time (FT), part time (PT) and per diem (PD) and volunteers will be educated to the facility□s use of the Emergency Preparedness Summary Sheet for residents by the LNHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff, residents, and volunteers. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) A quarterly room rounds by the LNHA or Admissions Coordinator for six (6) months then quarterly thereafter until otherwise determined by the QAA committee; confirming the presence of the Emergency Preparedness Summary Sheet. This review shall also be	

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E 035	Continued From page 21	E 035	conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan; b) A semi-annual review of the Emergency Preparedness Summary Sheet will be reviewed in Resident Council meetings by the LNHA semi-annually x one (1) year and then as determined by the QAA committee.	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must	E 036		6/25/18

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develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have a written training and testing program for staff.

The findings included:

During an interview on 5/17/18 at 12:36 P.M. with the administrator, Quality Assurance Coordinator and the Maintenance Director the administrator was asked for documentation that the facility had an emergency preparedness plan written training and testing program. The administrator stated, the facility did not have a written training and testing program.

The facility staff failed to have a written emergency preparedness training and testing program.

E 036

E036
1. The facility provides emergency preparedness training during orientation for all newly hired employees and volunteers as well as annually thereafter. The LNHA has scheduled a written testing of its□ Emergency Preparedness Plan by 6-25-18. Following the conclusion of the testing, the LNHA will review the facility□s emergency preparedness plan; ensuring its□ application to be sound.

2. All Residents have the potential to be affected. The facility provides emergency preparedness training during orientation for all newly hired employees and volunteers as well as annually thereafter. The LNHA has scheduled a written testing of its□ Emergency Preparedness Plan by 6-25-18. Following the conclusion of the testing, the NHA will review the facility□s emergency preparedness plan; ensuring its□ application to be sound.

3. The Emergency Preparedness Plan and related training will be reviewed in the QAA committee on 7-18-18.

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E 036	Continued From page 23	E 036	Following this review, recommendations, and/or further enhancements, this written plan and testing will become a component of the facility□s Emergency Preparedness Manuals. All staff, full time (FT), part time (PT) and per diem (PD) and volunteers will be educated to the facility□s use of the Emergency Preparedness Plan by the LNHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) the LNHA will conduct a testing of the facility□s emergency preparedness plan semi-annually. Following the semi-annual testing, the NHA will evaluate the emergency preparedness plan related to the testing; ensuring its□ application is sound; b) The QAA committee will review the emergency preparedness plan and semi-annual testing; ensuring compliance with regulations and the facility□s plan. This review shall also be conducted following a full-scale exercise or real emergency; evaluating the facility□s effective plan.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:	E 037		6/25/18

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E 037	Continued From page 24 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with	E 037		

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special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services

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under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain

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E 037	Continued From page 27 documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the facility's initial emergency preparedness training program and staff have received initial training. The findings included: During an interview on 5/17/18 at 12:39 P.M. with the administrator, Quality Assurance Coordinator and the Maintenance Director, the administrator was asked for documentation of the facilities initial emergency preparedness training program and documentation that staff have received initial training. The administrator stated, staff have not received initial emergency preparedness training. The facility staff failed to have an initial emergency preparedness training program.	E 037	E037 1. The facility provides emergency preparedness training during orientation for all newly hired employees and volunteers as well as annually thereafter for all staff. The LNHA has scheduled the annual emergency preparedness training for all staff by 6-25-18. 2. All residents have the potential to be affected. The facility provides emergency preparedness training during orientation for all newly hired employees as well as annually thereafter for all staff. The LNHA has scheduled the annual emergency preparedness training for all staff and volunteers for by 6-25-18. 3. The Emergency Preparedness Plan and related training will be reviewed in the QAA committee on 6-20-18. Following this review, recommendations or revisions will be made, as needed, to the facility□s Emergency Preparedness Manuals. All staff, full time (FT), part time (PT) and per diem (PD) and volunteers will be educated to the facility□s use of the Emergency Preparedness Plan by the NHA by 6-25-18. Emergency preparedness education shall occur at least annually with all staff.	

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E 037	Continued From page 28	E 037	4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) The HR Director, LNHA or Maintenance Director will conduct an initial training of the facility□s emergency preparedness plan during orientation for all new hires and new volunteers; b) the LNHA will conduct an annual training of the facility□s emergency preparedness plan for all staff. c) The QAA committee will review the emergency preparedness plan and training annually; ensuring compliance with regulations and the facility□s plan.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard survey was conducted 05/15/18 through 05/17/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care and the Virginia State Long Term Care requirements. One complaint was investigated during the survey. The census in this 60 bed certified facility was 51 at the time of the survey. The survey sample consisted of 16 current resident reviews (Resident #1, #4, #5, #8, #9, #14, #16, #19, #20, #22, #24, #31, #33, #36, #42, and #102) and 2 closed records (Resident #50a and 50b).	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		6/25/18

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Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility failed to notify the State Long Term Care Ombudsman of transfers to the hospital for 5 of 18 Residents in the survey sample (Resident #36, #30, #8, #31, and #33).

The findings included:

1. Resident #36 was admitted to the facility on 10/28/16. Diagnoses for Resident #36 included but are not limited to Alzheimer's Disease. Resident #36's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/4/16 coded Resident #36 with a BIMS (Brief Interview for Mental Status) score of 8 out of a possible 15 indicating a moderate cognitive impairment.

Resident #36 was hospitalized on 3/15/18 after being found lying on the floor, on the right side of her bed by a CNA, the bed was in a high position per a 3/16/18 Late Entry 16:03 (4:03 PM) (nursing

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Disclaimer Notice:
Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but instead is prepared for the sole purpose of compliance with State and Federal Regulations.

F623
1. The facility contacted the Ombudsman on 5-23-18 related to Resident #36, #30, #31, #33s emergency department transfers as well as Resident #8s discharge to the hospital. The facility has spoken with the Ombudsman on 5-23-18 confirming her desire to be notified on a weekly basis of all transfers and discharges via fax. This revised process activated on 5-25-18.

2. All residents have the potential to be affected. Notices for all residents

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note).

Review of Resident #36's clinical record revealed an Emergency Room note dated 3/15/18 that documented the following discharge diagnosis:

non-displaced fracture of second cervical vertebra, unspecified, fracture
Closed fracture of transverse process of cervical vertebra
Fall

Resident was released back to the facility on 3/15/18 with discharge education/instructions for a Broken Neck.

The State Long Term Care Ombudsman was not informed of Resident #36's transfer to the hospital Emergency Department.

Notification of Transfer: An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They had not been sending notification of discharges to the local Ombudsman office; we didn't know we had too. The SW stated, "We really weren't aware that we needed to notify the Ombudsman each time a resident was discharged out to the hospital.

An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they were discharged out to the hospital." The BOM stated, "We would have been giving the bed hold

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transferred emergently and/or discharged from the facility over the past thirty (30) days (1) have been forwarded to the Ombudsman along a copy of the facility□s current resident roster.

3. The facility has reviewed its□ policies on Transfer-Discharge Notification; confirming the practice of Ombudsman notification with emergency transfers or discharges of residents. No revisions are needed at this time. Discussions with the Ombudsman confirms the desire to be notified weekly of all emergency transfers and discharges. The Ombudsman wishes to be notified via fax. The facility has created a tracking log wherein resident emergency transfer and discharge dates are entered along with ombudsman notification dates. Ombudsman notification shall be the responsibility of the Social Services Representative or LNHA. The Social Service Representative will be re educated to the policy and tracking tool by the LNHA.

4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) The Social Service representative will maintain the resident transfer/discharge log; notifying the Ombudsman of resident transfers and discharges via fax. She shall maintain the fax confirmation of this communication with the Ombudsman for verification; b) The LNHA will review the resident emergency transfer/discharge log

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F 623	Continued From page 33 policy to resident or their representative; if we had known but we were not aware." The BOM stated, "We would notify the resident or their representative of the bed hold policy if there was change and it was a possibility of filling their bed." She proceeded to say, the resident was given the opportunity to hold their bed and if they want to pay we would give them a form to sign. The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings. 2. Resident #30 was admitted into the facility on 6/6/14. Diagnosis for Resident #30 include but are not limited to Dementia. Resident #30's Annual MDS (Minimum Data Set) (an assessment protocol) with an Assessment Reference Date of 12/21/16 coded Resident #36 with a BIMS (Brief Interview for Mental Status) score of 12 out of a possible 15 indicating a moderate cognitive impairment. Review of Resident #30's clinical record revealed Resident #30 went to hospital on 11/25/17 and 2/13/18. The State Long Term Care Ombudsman was not informed of Resident #30 transfer to the hospital Emergency Department. Notification of Transfer: An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at	F 623	weekly x four (4) weeks then monthly thereafter; confirming accuracy completion; c) The LNHA will review the resident emergency transfer/discharge log with the ombudsman upon each visit (if amenable); confirming his/her awareness of the resident emergency transfers/discharges; d) Monthly for three (3) months and quarterly thereafter x one (1) year, the resident emergency transfer/discharge log will be reviewed by the QAA committee; confirming compliance with the above. Variances will be addressed promptly. The QAA team will determine the frequency of continued and ongoing monitoring.	

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approximately 10:15 a.m. The BOM stated, "They had not been sending notification of discharges to the local Ombudsman office; we didn't know we had too. The SW stated, "We really weren't aware that we needed to notify the Ombudsman each time a resident was discharged out to the hospital.

An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they were discharged out to the hospital." The BOM stated, "We would have been giving the bed hold policy to resident or their representative; if we had known but we were not aware."

The BOM stated, "We would notify the resident or their representative of the bed hold policy if there was change and it was a possibility of filling their bed." She proceeded to say, the resident was given the opportunity to hold their bed and if they want to pay we would give them a form to sign.

The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings.

3. The facility staff failed to notify the Ombudsman of a discharge to the hospital for Resident #8.

Resident # 8 was re-admitted to the facility on 1/24/18 with diagnoses of seizures, cerebral

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palsy, chronic contractures, hypertension, severe intellectual disabilities and comfort measures. Resident #8 was sent out to the hospital emergency room on 1/16/18. The facility staff failed to notify the Ombudsman of his discharge.

A Quarterly Minimum Data Set (MDS) dated 11/30/17 assessed this resident in the area of Cognitive Pattern as having memory problems. In the area of Cognitive Skills for daily decision making as severely impaired.

A revised Care Plan dated 12/6/17 indicated: Focus: Resident #8 has impaired cognition communication and/or impaired thought processes. Intervention- Introduce self frequently, add validation, visual cues, and gestures. Speak slowly and distinctly, maintain calm relaxed manner, observe body language for communicating needs.

A nursing note dated 1/16/18 included: 'Resident #8 had a temperature of 102 degrees. Resident #8 was sent to Emergency Room.

During an interview on 5/16/18 at 10:15 A.M. with the Social Worker (SW) and the Business Manager (BOM), the BOM stated, " They had not been sending notification of discharges to the Ombudsman office. We didn't know we had too." The SW stated, "We really weren't aware that we needed to notify the Ombudsman each time a resident was discharged out to the hospital."were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they were discharged out to the hospital."

The facility staff failed to notify the Ombudsman

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of a discharge out to the hospital.

4. Resident #31 was originally admitted to the facility on 08/26/16. Diagnosis for Resident #31 included but not limited to *Hydronephrosis with renal and ureteral calculous obstruction.

*Hydronephrosis is distension of the pelvic and calyces of the kidney by urine that cannot flow past an obstruction in a ureter.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 4/2/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments was dated for
3/13/18 - discharge return anticipated and
1/29/18 - discharge return anticipated.

On 3/13/18, according to the facility's documentation, Resident #31 was found alert with left nephrostomy tube dislodge. Resident #31 was transport to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 3/20/18.

On 1/29/18, according to the facility's documentation, 911 was called and resident was transferred to local ER due to pain right side abdomen that was being relieved with pain medication. Resident's vital signs were; BP (124/82), P (102), R (30), T (99.5), Resident #31 was started on 02 at 2 L/min. Resident returned to the facility on 2/13/18.

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THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

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An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not sending notification of discharges to the local Ombudsman office; we didn't know we had too. The SW stated, "We really weren't aware that we needed to notify the Ombudsman each time a resident was discharged out to the hospital.

The facility administration was informed of the findings during a briefing on 05/17/18. The facility did not present any further information about the findings.

5. Resident #33 was originally admitted to the facility on 12/7/17. Diagnosis for Resident #33 included but not limited to *End Stage Renal Disease (ESRD).

*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failur e).

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 4/3/18 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments was dated for 3/15/18 - discharge return anticipated and 2/10/18 - discharge return anticipated.

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On 3/15/18, according to the facility's documentation, "Resident #33 was noted without bruit and thrill to right arm AV Fistual site. AV Fistual site was noted to be without sutures and no dehiscence of incision margins observed. Site noted with moderate amount of serosanquinous exudate. The Nurse Practitioner (NP) was made aware with new order to send to local ER with medical transport services for evaluation." The resident returned to the facility on 3/20/18.

On 2/10/18, according to the facility's documentation, Resident #33 returned from dialysis; refused oral medications but denies pain or discomfort. Resident #33 later called 911 with complaints that his left forearm AV Fistual site was protruded but was without edema. The MD was notified with new orders to send to local ER for evaluation. The resident returned to the facility on 2/15/18.

An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not sending notification of discharges to the local Ombudsman office; we didn't know we had too. The SW stated, "We really weren't aware that we needed to notify the Ombudsman each time a resident was discharged out to the hospital.

The facility administration was informed of the findings during a briefing on 05/17/18. The facility did not present any further information about the findings.

The facility's policy titled Transfer or Discharge Notice (Revision 2017).

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F 623	Continued From page 39 -Notice of Transfer or Discharge or Discharge and Ombudsman Notification - For facility-initiated transfer or discharge of a resident, the facility must notify the resident and the resident's representative(s) (RR) of the transfer or discharge and the reasons for the move in writing and in a language and manner, they must understand. Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. -Emergency Transfer- When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and RR as soon as practicable, according to 42 CRF 483.15 (c)(4) (ii) (D). Copies of notices for emergency transfers must also be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625		6/25/18

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(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility failed to ensure 5 of 18 Residents in the survey sample (Resident #36, #30, #8, #31, and #33) received information on the facility bed hold policy prior to transfer to hospital.

The findings included:

1. Resident #36 was admitted to the facility on 10/28/16. Diagnoses for Resident #36 included but are not limited to Alzheimer's Disease. Resident #36's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/4/16 coded Resident #36 with a BIMS (Brief Interview for Mental Status) score of 8 out of a possible 15 indicating a moderate cognitive impairment.

Review of Resident #36's clinical record revealed

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F625
1. The facility did not re occupy beds previously assigned Resident #36, #30, #31, #33 and #8 following his/her emergency department transfers or discharges; admitting the above residents back to his/her room upon their return to the facility. All residents upon admission are alerted to the facility□s bed hold policy via Admission Contract. A copy of the facility□s Bed Hold policy has been attached to the facility□s transfer form for automatic inclusion at point of emergency transfer or discharge.

2. All residents have the potential to be affected. The facility has conducted a review of all residents emergently transferred or discharged and who returned to the facility in the past thirty (30) days; confirming the return to his/her

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Resident #36 was hospitalized on 3/15/18 after being found lying on the floor, on the right side of her bed by a CNA, the bed was in a high position per a 3/16/18 Late Entry 16:03 (4:03 PM) (nursing note). Resident was released back to the facility on 3/15/18 with discharge education/instructions for a Broken Neck.

An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they were discharged out to the hospital." The BOM stated, "We would have been giving the bed hold policy to resident or their representative; if we had known but we were not aware."

The BOM stated, "We would notify the resident or their representative of the bed hold policy if there was change and it was a possibility of filling their bed." She proceeded to say, the resident was given the opportunity to hold their bed and if they want to pay we would give them a form to sign.

The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings.

2. Resident #30 was admitted into the facility on 6/6/14. Diagnosis for Resident #30 include but are not limited to Dementia.

Resident #30's Annual MDS (Minimum Data Set) (an assessment protocol) with an Assessment

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previously selected bed and room. The facility confirms that all beds were held for the residents. A copy of the facility□s Bed Hold policy has been attached to the facility□s transfer form for automatic inclusion at point of emergency transfer or discharge.

3. The facility has reviewed its□ policy related to Holding Bed Space; acknowledging the need to notify the resident/responsible party of the facility□s bed hold policy within twenty-four (24) hours of emergency transfer or discharge. No revisions to the policy are needed. A copy of the facility□s bed hold policy has been attached to the facility□s transfer form for automatic inclusion at point of emergency transfer and discharge. The Admissions Coordinator or Social Services representative will conduct a follow up call with the resident/responsibility within two (2) business days to determine one□s interest in activating a bed hold. This discussion and decision shall be documented on a log and communicated to the interdisciplinary team as appropriate. All department directors shall be re educated to this policy and practice by the LNHA.

4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) the Admissions Coordinator or Business Office Manager will ensure that all

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Reference Date of 12/21/16 coded Resident #36 with a BIMS (Brief Interview for Mental Status) score of 12 out of a possible 15 indicating a moderate cognitive impairment.

Resident #30 went to hospital on 11/25/17 and 2/13/18.

An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they were discharged out to the hospital." The BOM stated, "We would have been giving the bed hold policy to resident or their representative; if we had known but we were not aware."

The BOM stated, "We would notify the resident or their representative of the bed hold policy if there was change and it was a possibility of filling their bed." She proceeded to say, the resident was given the opportunity to hold their bed and if they want to pay we would give them a form to sign.

The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings.

3. The facility staff failed to notify Resident #8 or his representative of the facilities bed hold policy when the resident was discharged to the hospital.

Resident # 8 was re- admitted to the facility on 1/24/18 with diagnoses of seizures, cerebral

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transfer forms include a copy of the facility□s bed hold policy and practice for immediate notification upon emergency transfer or discharge; b) the Admissions Coordinator or Business Office Manager will contact the resident/responsible party within two (2) business days of all emergency transfers determining one□s interest in activating a bed hold. This discussion and decision shall be documented on a log; c) the LNHA will review the log monthly x three (3) months and then quarterly thereafter; ensuring process consistency and regulatory compliance. Variances will be addressed promptly; and d) the log shall be maintained and reviewed monthly in QAA committee x three (3) months and then quarterly x until otherwise determined by the QAA team.

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palsy, chronic contractures, hypertension, severe intellectual disabilities and comfort measures. Resident #8 was sent out to the hospital emergency room on 1/16/18.

A Quarterly Minimum Data Set (MDS) dated 11/30/17 assessed this resident in the area of Cognitive Pattern as having memory problems. In the area of Cognitive Skills for daily decision making as severely impaired.

A revised Care Plan dated 12/6/17 indicated: Focus: Resident #8 has impaired cognition communication and/or impaired thought processes. Intervention- Introduce self frequently, add validation, visual cues, and gestures. Speak slowly and distinctly, maintain calm relaxed manner, observe body language for communicating needs.

A nursing note dated 1/16/18 indicated: 'Resident #8 had a temperature of 102 degrees. Resident #8 was sent to Emergency Room.

During an interview on 5/16/18 at 10:15 A.M. with the Social Worker (SW) and the Business Manager (BOM), the BOM stated, " They were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they were discharged out to the hospital." The BOM stated, "We would have been giving the bed hold policy to residents or their representative if we had none." The BOM stated, "We would notify the resident or their representative of the bed hold policy if there was change and it was a possibility of filling their bed." The BOM proceeded to say, "The resident was given the opportunity to hold their bed and if they

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want to pay we would give them a form to sign.

The facility staff failed to notify residents or their representative of the facility's bed hold policy.

4. Resident #31 was originally admitted to the facility on 08/26/16. Diagnosis for Resident #31 included but not limited to *Hydronephrosis with renal and ureteral calculous obstruction.

*Hydronephrosis is distension of the pelvic and calyces of the kidney by urine that cannot flow past an obstruction in a ureter.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 4/2/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments was dated for 3/13/18 - discharge return anticipated and 1/29/18 - discharge return anticipated.

On 3/13/18, according to the facility's documentation, Resident #31 was found alert with left nephrostomy tube dislodge. Resident #31 was transport to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 3/20/18.

On 1/29/18, according to the facility's documentation, 911 was called and resident was transferred to local ER due to pain right side abdomen that was being relieved with pain medication. Resident's vital signs were; BP

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(124/82), P (102), R (30), T (99.5), Resident #31 was started on 02 at 2 L/min. Resident returned to the facility on 2/13/18.

An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they were discharged out to the hospital." The BOM stated, "We would have been giving the bed hold policy to resident or their representative; if we had known but we were not aware."
The BOM stated, "We would notify the resident or their representative of the bed hold policy if there was change and it was a possibility of filling their bed." She proceeded to say, the resident was given the opportunity to hold their bed and if they want to pay we would give them a form to sign.

The facility administration was informed of the findings during a briefing on 05/17/18. The facility did not present any further information about the findings.

5. Resident #33 was originally admitted to the facility on 12/7/17. Diagnosis for Resident #33 included but not limited to *End Stage Renal Disease (ESRD).

*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failur e).

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The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 4/3/18 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments was dated for
3/15/18 - discharge return anticipated and
2/10/18 - discharge return anticipated.

On 3/15/18, according to the facility's documentation, "Resident #33 was noted without bruit and thrill to right arm AV Fistual site. AV Fistula site was noted to be without sutures and no dehiscence of incision margins observed. Site noted with moderate amount of serosanquinous exudate. The Nurse Practitioner (NP) was made aware with new order to send to local ER with medical transport services for evaluation." The resident returned to the facility on 3/20/18.

On 2/10/18, according to the facility's documentation, Resident #33 returned from dialysis; refused oral medications but denies pain or discomfort. Resident #33 later called 911 with complaints that his left forearm AV Fistual site was protruded but was without edema. The MD was notified with new orders to send to local ER for evaluation. The resident returned to the facility on 2/15/18.

An interview was conducted with the Social Worker (SW) and Business of Manager (BOM) on 5/16/18 at approximately 10:15 a.m. The BOM stated, "They were not aware that the resident or their representative should have been given a copy of the bed hold policy each time they

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were discharged out to the hospital." The BOM stated, "We would have been giving the bed hold policy to resident or their representative; if we had known but we were not aware."
The BOM stated, "We would notify the resident or their representative of the bed hold policy if there was change and it was a possibility of filling their bed." She proceeded to say, the resident was given the opportunity to hold their bed and if they want to pay we would give them a form to sign.

The facility administration was informed of the findings during a briefing on 05/17/18. The facility did not present any further information about the findings.

The facility's policy titled Bed Hold and Readmission Process (Revision 2017).

-Should the resident required a transfer from the facility, for any reason, the facility will include but not limited to:

-Complete the facility "Bed Hold Notice" which is attached to the "Transfer Form. This Bed Hold Notice shall have the resident name, the facility name, and the date of transfer entered onto the notice. Upon completion of this form, the facility shall provide the resident or the transportation entities with this form for delivery to the receiving entity.

-The copy of the resident specific and dated bed hold notice is copied and forwarded to the Business Office for mailing.

-Within twenty-four (24) hours of the resident transfer, the resident specific copy of the bed hold notice is copied and mailed to the resident's

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F 625	Continued From page 48 known agent/RP/guardian via return receipt, certified mail. -One carbon copy of the resident specific bed hold notice shall be maintained in the resident's administrative file with the mailing receipt affixed. -Upon receipt of the "received" confirmation card confirming receipt by the agent, the US postal confirmation card is affixed to the existing bed hold notice in the resident's administration file and maintained there for safe keeping. -Also within twenty-four (24) hours of the resident's transfer (as applicable) the Business Office Manager/designee will telephone the resident's known agent/RP/guardian notifying them of the bed hold option. This call is not in place of the mailing noted above. However, this telephone call is document and date specific.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation the facility staff failed to ensure that 1 of 18 residents (Resident #16) in the survey sample received a complete and accurate assessment. The findings include: Resident #16 was admitted to the facility 10/18/17. Diagnosis for Resident #16 included	F 641	F641 1. Resident #16 remains at baseline. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2-16-18 was modified to reflect the Anti-anxiety agent usage during the seven (7) day look back period in accordance with the Resident Assessment Instrument (RAI) manual.	6/25/18

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F 641	Continued From page 49 but not limited to *Anxiety disorder. *Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm). Resident #16's MDS with an Assessment Reference Date (ARD) of 02/26/18 coded resident with a BIMS score of 15 out of a possible 15 indicating no cognitive impairment. Review of Resident #16's quarterly MDS with an ARD of 02/26/18 was coded 0 for receiving *antianxiety medications. The section N on the MDS under medications received read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, enter "0" if medication was not received by the resident during the last 7 days. Resident #16's comprehensive care plan documented resident with use of Anti-anxiety medications used for the diagnosis of anxiety. The goal: will have no issues related to anxiety medications. Some of the intervention to manage goal included medication as ordered and evaluate medication use. The physician order reads: Starting on 11/30/17 - Clonazepam 1 mg tablet -give 1 tablet by mouth twice daily. *Clonazepam is an anxiety medication (https://www.medicinenet.com/clonazepam/article.htm).	F 641	2. The facility has conducted a review of all current residents whose plan of care includes any psychoactive medications (including anti-anxiety, hypnotics, anti-depressants, and anti-psychotics). The review compared the resident□s MAR and coding to section N0410A-D during the resident□s most current MDS; ensuring the accurate coding of section N0410A-D. No variances were identified. 3. The facility has the most current copy of the RAI manual and the MDS coordinator was able to verbally re-demonstrate her understanding of the coding requirements for section N0410A-D. The facility has reviewed its□ policy on Resident Assessment acknowledging the expectation of accuracy. The MDS nurse has been re educated to section N0410 RAI manual coding description by the Director of Nursing (DON). 4. The LHNA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) The MDS nurse shall maintain a log reflecting current residents□ usage of psychoactive medications comparing his/her MAR□s and MDS section N0410A-D coding for one (1) month. This log will be reviewed by the DON for accuracy. Variances will be modified in accordance with the RAI manual. This log and responsive action will be reviewed by the QAA committee x one (1) month; b)	

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F 641	Continued From page 50 Review of Resident #16's February 2018 Medication Administration Record (MAR) revealed the medication Clonazepam was administered twice daily for the entire month. An interview was conducted with MDS Coordinator on 5/17/18 at approximately 11:42 a.m., who stated, "Yes, the medication *Clonazepam is an antianxiety medication and you were right, it should have been coded a 7 for the days received on the 2/26/18 MDS." The facility administration was informed of the finding during a briefing on 05/17/18. The facility did not present any further information about the findings. CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI) 1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status. Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.	F 641	Should no variances be identified, the MDS nurse shall continue to track and compare current resident□s MAR□s and related MDS coding for section N0410A-D for up to 30% of the residents receiving psychoactive medications quarterly x six (6) months. This log will be reviewed by the DON for accuracy. Identified variances will be modified in accordance with the RAI manual. This log shall be reviewed by the QAA committee who shall determine the frequency of continued ongoing monitoring.	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		6/25/18

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F 687 Continued From page 51
and care to maintain mobility and good foot health, the facility must:
(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and
(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 18 residents (Resident #31) in the survey sample who were unable to carry out activities of daily living receives the necessary services to maintain toenail care.

The facility staff failed to ensure that podiatry services was provided to Resident #31.

The findings include:

Resident #31 was originally admitted to the facility on 08/26/16. Diagnosis for Resident #31 included but not limited to *Parkinson.

*Parkinson is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people (https://www.webmd.com).

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 04/02/18 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score

F 687

F687
1. Resident #31 had his toenails assessed and trimmed by the podiatrist on 5-16-18.

2. The facility conducted a review of all current residents; ensuring his/her fingernails and toenails to be clean and trimmed. Variances were promptly addressed by either trained staff members or the podiatrist.

3. The facility reviewed its policy on Care of Fingernails and Toes ensuring clarity. No revisions were needed. The facility reviewed its Shower Sheet form to confirm the inclusion of fingernails and toenails. The facility conducts routine skin checks on current residents and has added fingernail and toenail checks to the skin checks process. All nursing staff, full time (FT), part time (PT) and per diem (PD) will be re educated to the facility policy on Care of Fingernails and Toes, shower sheets, and the expectation of checking a resident's fingernails and toenails during routine skin checks.

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F 687	Continued From page 52 of 15, which indicated no cognitive impairment for daily decision-making. The resident was not coded for rejection of care to include Activities of Daily Living (ADL). Resident #31 was coded to require extensive assistance of one staff for personal hygiene. Resident #31's comprehensive care plan indicated actual ADL self-care performance deficit r/t Parkinson's and needs assistance with ADL's. On 5/16/18 at approximately 8:24 a.m., an interview was conducted with Resident #31 who stated my toenails are never cut and they hurt sometimes. On 5/16/18 at approximately 8:45 a.m., License Practical Nurse (LPN) #16 and this surveyor assessed resident's toenails. On the left foot 2nd digit the nail was long, curved under the toe and came in direct contact with Resident #31's skin, the 4th digit was red in color, the LPN palpated the digit and asked if it hurt; the resident replied, "Yes." The LPN stated, "The podiatrist need to come see this guy, he needs to come now." This surveyor and LPN #16 reviewed the podiatry list located at the nurse's station in the podiatry book; Resident #31's name was not on podiatry list; the LPN added Resident #31 to the podiatry list. An interview was conducted wit Director of Nursing (DON) on 5/17/18 at approximately 9:55 a.m., who stated, "Whoever finds that a resident need podiatry services, I expect for the staff member to notify nursing or myself so that podiatry services can be done." The DON proceed to say the Certified Nursing Assistant (CNA's) should be looking at toenails and fingernail when doing ADL care. The DON also	F 687	4. The LNHA is responsible for the POC implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The Unit Manager (UM) or DON will review the resident Showers Sheets weekly x four (4) weeks ensuring completion which includes the status of one�s fingernails and toenails; b) The UM or DON will spot check up to 20% of current residents confirming that that which was recorded on the Shower Sheets is an accurate reflection of the resident�s toenail or fingernail condition. Should findings vary from that documented by staff, the UM or DON will review up to 100% of the resident�s fingernails and toenails confirming them to be clean and trimmed; b) Staff nurses will conduct bi-weekly skin checks x two (2) months which includes fingernail and toenail checks; confirming them to be clean and trimmed. The UM or DON will spot check up to 20% of current residents confirming that that which was recorded on the skin check sheet is an accurate reflection of the resident�s toenail or fingernail condition. Should findings vary from that documented by staff, the UM or DON will review up to 100% of the resident�s fingernails and toenails confirming them to be clean and trimmed Variances will be promptly addressed. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.	

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F 687	Continued From page 53 said the podiatrist saw Resident #31 today. Review of the resident's medical record on 5/17/18 revealed that the podiatrist came in on 5/17/18 and provided toenail care to Resident #31. On the same day, this surveyor observed Resident #31's toenails were cut and trimmed. The facility administration was informed of the finding during a briefing on 5/17/18. No additional information was provided. The facility's policy titled (Care of Fingernails/Toenails). Purpose: The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines: -Nail care includes daily cleaning and regular trimming. -Proper nail care can aid in the prevention of skin problems around the nail bed. -Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. -Watch for and report any changes in the color of the skin round the nail bed, blueness of the nails, and signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. -Stop and report to the nurse supervisor if there is evidence of ingrown nails infections, pain, or if nails are too hard or thick to cut with ease.	F 687		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		6/21/18

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F 689	Continued From page 54	F 689		

The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to ensure one resident (Resident #36), of 18 residents in the survey sample, remained free of accident hazard that resulted in a fall with fracture that resulted in harm of past non compliance.

Past noncompliance: no plan of correction required.

The findings included:

Resident #36 was admitted to the facility on 10/28/16. Diagnoses for Resident #36 included but were not limited to Alzheimer's disease and Cervical Fracture.

Resident #36's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/4/16 coded Resident #36 with a BIMS (Brief Interview for Mental Status) score of 8 out of a possible 15 indicating a moderate cognitive impairment.

Resident #36 required extensive assistance with 2 staff member assist for bed mobility and transfers as documented on the Admission Minimum Data Set with an Assessment Reference Date of 11/4/16.

Resident #36 was hospitalized on 3/15/18 after being found lying on the floor, on the right side of

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F 689	Continued From page 55	F 689		

her bed by a CNA, the bed was in a high position per a 3/16/18 Late Entry 16:03 (4:03 PM) (nursing note).

An Emergency Room note dated 3/15/18 documented the following discharge diagnosis:

1. Nondisplaced fracture of second cervical vertebra, unspecified, fracture
2. Closed fracture of transverse process of cervical vertebra
Fall

Resident was released back to the facility on 3/15/18 with discharge education/instructions for a Broken Neck and a cervical collar.

A facility "Event Occurrence Report" dated 3/15/18 documented the following:

After event:
Date of Event: 3/15/18
Time of event: 14:15 (2:15 PM)
Type of event: fall
Cognitive Status: Alert, Able to understand others
ADL (Activity Daily Living): Transfer
Mood: Apathetic
Details of Incident: "found lying on floor next to bed per CNA. Reported to nurse. Lying on floor on right side of her bed. RN assessed the patient and asked me to call 911 to send to hospital. Resident was complaining of neck pain. The bed was in high position. The CNA was doing ADLs and walked away. The fall occurred
Type of Injury: Discomfort/pain
Identify the location of known injury or pain: Left side of neck
MD notified 3/15/18 14:15 (2:15 PM)

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RP notified: 3/15/18 14:20 (2:20 PM)

A 3/15/18 Nursing note Late Entry Created 3/16/18 16:03 (4:03 PM), for effective date 3/15/18 14:41 (2:41 PM) documented the following: "Resident was found lying on the floor, on the right side of her bed by CNA, the bed was in a high position. She was assessed, complained of neck pain, I was instructed to call 911, and send to hospital, the paramedic arrived and assessed the resident and transported to (hospital) she was alert and responsive, to all verbal command."

Resident #36's Fall Risk Assessment dated 3/19/18 documented a score of 15 indicating a high fall risk. A review done on 5/17/18 at approximately 3:35 PM, of an Event Occurrence Report dated 3/15/15 Resident #36, documented a fall on 3/15/15.

Resident #36's person centered care plan dated 10/28/17 with a revision on 12/28/18 documented the Focus area:

Focus Area: has the potential for fall related injury related to history of falls, incontinence, Alzheimer's
Goal: Will not injure themselves in a fall through next review
Interventions:
Anticipate and meet Resident's needs
Be sure Resident call light is within reach and encourage resident to use it for assistance as needed

Focus Area; has an injury related to fall with major injury
Goal: Resident will show sign symptoms of

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F 689	Continued From page 57 healing by next review date Interventions: 911 called for ER 3/15/18 Be sure call light is within reach and encourage Resident to use it for assistance as needed bi lat floor mats follow MD orders for injury Keep C collar on all the time A letter from the Facility's Administrator included with the Facility Reported Incident, dated 3/20/18 sent to the Office of Long Term Care and received 3/21/18 documented: ...The CNA stepped out of room to get a fitted sheet for 10-15 seconds and in that time, (Resident #36) rolled off the bed onto the floor mat which was in place on her floor. ... To deter reoccurrence of fall during ADL care, Staff have been re-educated on bed position and ADL safety during care. Redirect patient as needed. The Facility Policy titled, "Accidents/Incidents - Medical Director Review of", with a revision date of 2008 documented the following: "As part of the QA process, the Medical Director will work with the Director of Nursing Services, Administrator, and other departments to evaluate trends, patterns, and interventions: for example, reduction of medications that may increase fall risks and ways to improve evaluation of individual's safety risk factors." The Director of Clinical Services presented a Corrective Action Plan dated 3/16/18. The Action plan documented the following:	F 689		

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Bed in Highest position Variance: All residents have the potential to be affected.
a. Resident's beds have been observed to be left elevated.
b. Resident's have been left in elevated bed alone
c. Resident rolled out of bed while CNA left her in an elevated bed position

Corrective Action Plan: documented the following
1. 1 Resident had an event that resulted in a fracture.
2. Resident's beds need to be lowered prior to the staff member leaving the room
3. All nursing staff to be re-educated on Policy and Procedure of Resident safety
4. Charge nurse on duty to be responsible for ensuring beds are in lowest position.
5. Nursing Administration to audit rooms each shift daily for 4 weeks, then daily for 4 weeks then monthly thereafter.

On 5/27/18 at approximately 4:15 PM, the education log from the Corrective Action Plan was reviewed. The education was titled, "Bed In Lowest Position", and was conducted on 3/16/18. Review of the Facility's fall book documented 1 fall resulting in a fractured nose on 3/30/18, however no deficient practice was identified.

On 5/17/18, the Director of Clinical Services stated that she knew the Resident's fracture was because she was left in a high position when the aide left out of the room for a few seconds to get a fitted sheet. The DCS stated, "It's on us."

The Facility Policy titled, "Accidents and Incidents - Investigating and Reporting" with a revision date of 2014 documented:

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F 689	Continued From page 59 "All accidents or incidents involving residents.... occurring on our premises shall be investigated and reported to the administrator." The Facility Policy titled, "Preventing Resident Abuse", with a revision date of 8/2011 documented the following: "Identifying areas with the facility that may make abuse and or neglect more likely to occur and monitoring these areas regularly." The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings. Past non-compliance: The fall from a high bed position resulted in a neck fracture that constituted harm of past non compliance for Resident #36.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and	F 695	F695 1. Resident #20□s oxygen concentrator	6/25/18

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F 695	Continued From page 60 clinical record review, the facility staff failed to ensure an oxygen concentrator filter was free of dust and debris for 1 resident of 18 in the survey sample (Resident #20) The following observations were made of the Resident in her room while oxygen was in use by nasal cannula at 2 liters per minute. 5/15/18 at approximately 12:10 PM during intial tour: oxygen concentrator filter dusty; 5/16/18 at approximately 3:30 PM observed oxygen concentrator filter dusty; 5/17/18 Observation at approximately 2:08 PM oxygen filter dusty. Interview with Unit Manager (UM) LPN #12 was conducted on 5/17/18 at approximately 2:10 PM. LPN #12 was asked to come look at filter in the Resident's room, with surveyor. After she observed the oxygen filter the surveyor asked her what she saw. The LPN #12 stated, "It's full of dust. It's my 1st week- day 4 for me." The UM stated that she was uncertain whose responsibility it was to ensure the filters were cleaned. The DCS (Director of Clinical Services) stated on 5/17/18 that a company comes in to clean the oxygen concentrators. The DCS was asked how often the company comes to do clean filters, was the filter was noted to be dirty, and who would clean the filters. The DCS never answered the surveyor's question as to frequency of visits by the company. The Administrator on 5/17/18 at approximately 5:55 PM stated that the company does not come regularly to clean the oxygen concentrator filters	F 695	filter was cleaned and reinserted into the oxygen concentrator for continued use. Resident #20 remains at baseline. 2. The facility has conducted a review of all residents using oxygen concentrators; ensuring filters to be clean and free of dust and debris. No variances were identified. The facility has contacted the oxygen support company which assists with routine cleaning of oxygen concentrators; confirming the frequency of their visits and that all oxygen concentrators are checked. The oxygen support company has been alerted to the above noted variance. 3. The facility has reviewed its□ contract with the oxygen support company; confirming their continued service which includes the checking and cleaning of all oxygen concentrator filters. The facility reviewed its□ policy on Oxygen Therapy which includes the checking and cleaning of oxygen concentrator filters at least weekly-as needed. The facility will add an oxygen concentrator filter check to the residents□ Treatment Administration Record (TAR) for a weekly check for those resident□s receiving oxygen therapy. All nursing staff, full time (FT), part time (PT) and per diem (PD) will be re-educated to the facility policy on Oxygen Therapy and the oxygen support company□s routine schedule for oxygen concentrator checks. Staff will not be assigned to work after 6-25-18 until they attend the in-service.	

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F 695	Continued From page 61 and that from now on nurses will be responsible to clean and check the oxygen concentrator filters. The Facility Policy, titled "Departmental (Respiratory Therapy) - Prevention of Infection" with a Revision date of 2011, documented the following: Infection Control Considerations Related to Oxygen Administration 9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings.	F 695	4. The LNHA is responsible for the POC implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The staff nurses will conduct weekly checks of oxygen concentrators in use by resident□s receiving oxygen; confirming the filters to be clean and free of dust and debris; b) The UM or DON will conduct rounds with up to 40% of the residents□ receiving oxygen via oxygen concentrators monthly; confirming the filters to be clean of dust and debris. This shall occur monthly x two (2) months then quarterly thereafter x six (months); c) The UM or DON will also check up to 40% of the TAR□s confirming oxygen concentrator filter checks initialed as having been performed weekly x 4 weeks then monthly x three (3) months; confirming compliance with the oxygen concentrator filter check. Variances will be promptly addressed. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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:	F 698		6/25/18

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F 698

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Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to communicate an ongoing assessment for one of 18 residents (Resident #33) for monitoring of complications before and after dialysis treatment.

The facility staff failed to communicate an ongoing assessment with the dialysis center who attended an outpatient dialysis three days per week every Tuesday, Thursday and Saturday.

The findings included:

Resident #33 was originally admitted to the facility on 12/07/18. Diagnosis included but not limited to *End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week on Tuesdays, Thursdays and Fridays.

*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).

*Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.

*For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access.

F 698

F698

1. Resident #33 remains at baseline. The DON promptly contacted the assigned dialysis center reinforcing the ongoing need for communication about the resident while at the dialysis center. The DON promptly met with the licensed nursing staff on 5-23-18 alerting them to the expectation of consistent dialysis communication between the facility and the dialysis center. The facility reviewed its Dialysis Communication Sheet confirming clarity. This form has been enhanced.

2. All residents receiving hemodialysis have the potential to be affected. The facility conducted an audit of all current resident s receiving hemodialysis; ensuring that all residents have a Dialysis Communication Book, that all are sent to the dialysis center with a facility generated Dialysis Communication Sheet and that the same is returned with updated documentation. Variances identified have been promptly addressed and will be forwarded to QAA committee for review.

3. The facility has reviewed it s process of generating the Dialysis Communication sheets/books for residents receiving hemodialysis and made the following revisions: a) All licensed nurses have been re educated to the Dialysis Communication Sheet and Books for all resident s receiving hemodialysis; b) DON has contacted all dialysis centers; outlining the expectation of interactive communication on all residents receiving

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With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 04/03/18 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The MDS coded Resident #33 requiring extensive assistance of one with bathing, limited assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene. In addition, under section (O) for Special Treatments, Procedures and Programs was coded for dialysis.

Resident #33's comprehensive care plan indicated resident requires dialysis. The goals the facility staff set for the resident is to attend hemodialysis treatment as scheduled. Some of the interventions included but not limited to resident will attend hemodialysis treatments as scheduled, monitor labs and report to doctor as needed and weights per protocol.

Resident #33's physician orders contained the following order: May attend outside dialysis on Tues, Thurs and Saturday.

An interview was conducted with Registered

F 698

hemodialysis using the facilitys Dialysis Communication sheet; c) Residents scheduled for hemodialysis shall be placed on the 24-hour report on the day of hemodialysis; cueing the nurses to document the use of the Dialysis Communication Sheet and its return. Should the resident return to the facility without the facility generated Dialysis Communication Sheet, the shift nurse will notify nursing administration (DON or UM) who in turn contacts the dialysis center. All licensed nurses shall be educated to the above process.

4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) The UM or DON will review up to 50% of the Dialysis Communication Sheets/Dialysis Books weekly x four (4) weeks for residents receiving hemodialysis; confirming the compliance with the facilitys process; b) All residents receiving dialysis will be reviewed during At Risk meetings held routinely (e.g. weekly). During the At Risk meetings, the Dialysis Communication Sheets/Dialysis Books for the residents receiving dialysis will be reviewed; ensuring compliance with the process; c) The facility will conduct Chart Audits for up to 30% of residents receiving dialysis monthly x two (2) months and then quarterly x six (6) months; confirming the presence of inter-communication between the facility and the dialysis center. All variances will

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Nurse (RN) #7 on 5/15/18 at approximately 3:45 p.m., who stated, "Resident #33 doesn't normally take a communication book with him to dialysis but I will double check to make sure." The surveyor requested Resident #33's dialysis communication book, the RN stated, "I don't see it but let me double check."

An interview was conducted with License Practical Nurse (LPN) #15 on 5/15/18 at approximately 3:50 p.m., who stated, "We usually send a communication book to dialysis with a Dialysis Communication Record Form to be completed but it usually returns with not completed." The surveyor asked if she received any information on Resident #33 today since today was his dialysis days she replied, "They did not send anything back today but can't really say we sent his communication book with him today." The LPN proceeded to say; we do not get anything back from the dialysis center on a regular basis.

An interview was conducted with the Director of Nursing (DON) on 5/17/18 at approximately 10 a.m., who stated, "We were unable to locate Resident #33's dialysis communication book." We called the dialysis center and the transportation company; they do not have it." The DON said, "We have been having issues communicating with dialysis center and we always have to call to get information on how his dialysis went but normally if is there is a problem at dialysis, they will call." The surveyor asked, "What is your expectation from your nurses when a resident goes out to the dialysis center and returns without the Dialysis Communication Record not being completed, she replied, "The nurses should make sure the information returns

Provider's plan of correction (F 698): be addressed promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.

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F 698	Continued From page 65 to the facility completed." The facility's policy titled End Stage Renal Disease, Care of a Resident with (Revision 2017). -Policy statement: Residents with ESRD will be cared for according to currently recognized standards of care. -Policy Interpretation and Implementation include but not limited to: 4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: a. How the care plan will be developed and implement; b. How the information will be exchanged between the facilities;	F 698		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		6/25/18

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§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility, documentation review, clinical recorded review, the facility staff failed for one (Resident #33) of 18 residents in the survey sample, to ensure non-pharmacological interventions were attempted prior to administering a psychoactive medication.

For Resident #33, the facility staff failed to ensure non-pharmacological interventions were attempted prior to the administration of a as needed psychoactive medication (*Xanax).

*Xanax is used to treat anxiety and panic disorders (https://www.drugs.com).
The findings included:

The finding include:

Resident #33 was originally admitted to the facility on 12/07/18. Diagnosis included but not limited to *Anxiety Disorder.

*Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm).

F 757

F757
1. Resident #33 remains at baseline. The following non-pharmacological interventions have been routinely attempted for Resident #33: enjoys watching TV, movies, keeping up with the news, talking on the phone and napping. Licensed nurses have been re-educated to the importance of documenting attempted non-pharmacological interventions to reduce anxiety prior the administration of an as needed PRN medication in the progress notes. Resident #33s PRN Xanax has been discontinued.

2. The facility has conducted a review of current residents receiving as needed PRN psychoactive medications; ensuring non-pharmacological interventions are attempted, documented and care planned prior to the administration of PRN psychoactive medications. Documentation and/or administration variances were addressed promptly. Care Plans were enhanced as needed.

3. The facility has reviewed its processes related to offered and documented non-pharmacological

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The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 04/03/18 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The MDS coded Resident #33 requiring extensive assistance of one with bathing, limited assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene. In addition, the MDS was not coded for behaviors symptoms, rejection of care or wandering.

Resident #33's comprehensive care plan indicated resident uses anti-anxiety medications r/t Anxiety disorder. The goals the facility staff set for the resident is to show decreased episodes of signs and symptoms of anxiety. Some of the interventions included but not limited to: non-drug interventions-enjoys watching TV, movies, keeping up with the news, talking on the phone and napping, monitor/record occurrence of for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc) and document per facility protocol.

Review of Resident #33's Physician orders indicated the following medication order was written on 3/26/18: Xanax tablet 0.5 mg - give 1 tablet by mouth every 8 hours (PRN) (as needed) for anxiety.

During the review of Resident #33's Medication Administration Record (MAR) revealed the as needed Xanax was administered on the following days without non-pharmacological attempts made prior the administration of the anxiety

F 757

interventions for residents prior to the administration of prescribed PRN anti-anxiety agents. The facility has also reviewed its� monitoring process of the use of PRN psychoactive medications. Enhancements to both processes included a) documentation of all attempted non-pharmacological interventions in the nursing notes prior to the administration of PRN psychoactive medications; b) monitoring by UM or DON of all residents on PRN psychoactive medications ensuring non-pharmacological interventions are documented and care planned and that PRN psychoactive medications are re-evaluated by the prescriber for continued benefit within fourteen (14) days of activation. All licensed nurses shall be re educated to the above process.

4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The UM or DON will review up to 50% of all residents MAR�s and progress notes for whom PRN psychoactive medications are ordered and administered weekly x four (4) weeks then monthly x three (3) months; confirming the documentation of attempted non-pharmacological interventions prior to the use of the PRN psychoactive medications; b) The UM or DON will review up to 50% of all residents who are prescribed PRN psychoactive medications ensuring that prescribers

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F 757	Continued From page 68 medication. 1. Xanax was document as being administered without non-pharmacological interventions in March 2018 on the following days: 3/26/18, 3/27/18, 3/29/18 and 3/31/18. 2. Xanax was document as being administered without non-pharmacological interventions in April 2018 on the following days: 4/1- 4/5, 4/7, 4/9-18 and 4/20-4/30/18. 3. Xanax was document as being administered without non-pharmacological interventions in May 2018 on the following days: 5/1-5/16/18. On 5/17/18 at approximately 9:45 a.m., this surveyor requested the anxiety behavioral monitoring documentation for March, April and May for the use of Xanax from the Director of Nursing (DON). On the same day at approximately 10:55 a.m., the DON stated, "There are no behavioral monitoring documentation for Resident #33, I looked but was unable to locate any behavioral monitoring tracking documentation. The facility administration was informed of the findings during a briefing on 05/17/18. The surveyor asked the DON, "What should your nurses do before administering a prn anxiety medications" the DON stated, "I expect for the nurses to attempt non-pharmacological interventions prior to administering the medication and to document the results in their medical record." The facility's policy titled Psychoactive Medication Administration (inclusive of non-pharmacological	F 757	have re-evaluated the continued benefit of PRN psychoactive medications within fourteen (14) days of activation; c) During the At Risk meetings, residents receiving PRN psychoactive medications will be reviewed for both the use of non-pharmacological interventions and the fourteen (14) day re-evaluation process. Variances will be address promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.	

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F 757	Continued From page 69 interventions) (Revision 2017). -Policy: PRN psychoactive medications will be given as ordered by the MD with very few exceptions, the PRN (as needed) psychoactive medication be given only after individualized non-pharmacological interventions have been attempted. Anytime a resident has a PRN psychoactive medication as ordered, the staff will identify how the resident manifests the behavior or symptoms for which the psychoactive medication is ordered. The staff will develop individualized non-pharmacological interventions designed to assist the resident in returning to a state of emotional well-being without the use of PRN psychoactive medications.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		6/25/18

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the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on general observation of the nursing facility, staff interviews, the facility failed to ensure medications were labeled in accordance with currently accepted professional principles in 1 out of 3 facility medication carts.

The facility staff failed to ensure two *Lantus (insulin) pens were dated when open and one unopened Lantus pen was dated when placed on the medication cart.

*Lantus (insulin glargine) is a man-made form of a hormone that is produced in the body. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. Insulin glargine is long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours. Storing opened (in use) Lantus: Store the injection pen at room temperature (do not refrigerate) and use within 28 days (www.drugs.com/lantus.html).

The finding include:

On 5/16/18 at approximately 11:20 a.m., this surveyor inspected the split hall medication cart with License Practical Nurse (LPN) #16. Doing the inspection of the Lantus pens located inside the medication cart; two (2) Lantus pens where open with no open date and one Lantus pen was on the medication cart unopened with no date

F 761

F761

1. All opened, undated or undated but stored at room temperature Lantus Flex pens were discarded. Licensed nurses were promptly re-educated on 5-23-18 to the importance of dating flex pens upon removal from the refrigerator for med cart storage, upon opening flex pens; along with a twenty-eight (28)-day expiration date of the same.

2. All insulin dependent residents have the potential to be affected. All medication carts and medication refrigerators were assessed confirming that all open insulins were dated upon opening and/or all room stored insulins were dated upon removal from the refrigerator; all with an expiration date not to exceed 28 days from opening or removal from the refrigerator. No variances were identified.

3. The facility has reviewed its policy on Medication Storage which addresses insulin storage and dating upon opening and/or removal of insulin (e.g. flex pens) from the refrigerator. No revisions are needed. All licensed nurses will be re educated to the policy and expectation. Medication Storage (which addresses

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F 761 Continued From page 71

when the medication was stored on the cart. The two (2) Lantus pens were in use with a label that read, discard in 28 days after opening and the unopened Lantus pen had a sticker that read to discard after 28 days after opening. The surveyor asked LPN #16, "When was the in use Lantus pens opened, she replied "I don't know", the surveyor then asked "When was the unopened Lantus pen placed on the medication cart, she replied "I don't know; I have no way of knowing."

The Director of Nursing (DON) gave this surveyor a pamphlet on Lantus titled Lantus (Insulin Glargine injection) solution for subcutaneous injection prescribing information to read in part: -16.2 (Storage - Not in-in use (unopened) room temperature is good for 28 days and in use (opened) 28 days refrigerated or room temperature (http://products.sanofius/lantus/lantus.html).

An interview was conducted with DON on 5/17/18 at approximately 3:20 p.m. who stated, "All insulin's should be dated when opened and Lantus pens should be stored in the refrigerator until open.

The facility administration was informed of the finding during a briefing on 5/17/18. The facility did not present any further information about the findings

The facility's policy titled Insulin Storage -Policy Statement: The facility shall store insulin in accordance with pharmaceutical standards.

Policy Interpretation and Implementation (General Rules)

F 761

insulin storage) is included in new nurse orientation.

4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) the assigned staff nurse, UM and/or DON will check insulin storage weekly x four (4) weeks then monthly x three (3) months; confirming accurate storage, dating of insulins once open or removed from the refrigerator and discarding of insulins after 28 days from removal from the refrigerator and/or once opened for use; b) The Medication and Diversion Audit will be conducted by the UM or DON monthly x two (2) months and then quarterly x one (1) year which includes the monitoring of insulin storage and dating. Variances will be address promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.

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F 761	Continued From page 72 -To ensure that your insulin remains effective, stable and undamaged you should discard your 'in use' insulin after 28 days, whether in a vial or cartridge. -Insulin that is not in use should be stored in the refrigerator. If refrigeration is not possible, it can be kept at room temperature (15-25 degrees Celsius) for 28 days. The facility's policy title Storage of Mediations (Revision 2017). -Policy statement: The facility shall store all drugs and biologicals in a safe secure, and orderly manner. Policy Interpretation and Implementation include but not limited to- -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and be labeled accordingly.	F 761		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure the facility garbage/refuse container door remained closed when not in use. The Facility Staff Failed to ensure the outside facility garbage/refuse container door was closed when it was not in use.	F 814	F814 1. The open dumpster door was closed. 2. No other dumpsters are located on the property. 3. A review of the facility□s policy Dispose of Garbage and Refuse has been conducted ensuring clarity. No revisions	6/25/18

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F 814

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The findings included:

On 05/15/18 at approximately 11:18 AM, during the initial Kitchen tour, it was observed that the outside garbage/refuse container had one door open upon inspection with the Dietary Manager.

On 5/15/18 at approximately 11:18 AM, the dietary Manager stated that he had just completed checking the garbage container doors. The Dietary Manager stated that in addition to Kitchen staff who dump garbage 3 times a day, the Housekeeping unit also empties garbage into the dumpster. In addition, the Dietary Manager stated that the facility policy is to keep the doors to the garbage can closed.

The Facility Policy titled, "Dispose of Garbage and Refuse" with a date of 8/2017 documented the following:

All garbage and refuse will be collected and disposed of in a safe and efficient manner.

The Dining Services Director will ensure that: Appropriate lids are provided for all containers.

The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings.

F 814 (Plan of Correction)

are needed. The facility has activated a twice daily check of the dumpster with documentation. All housekeeping and dietary staff will be re-educated to the policy and expectation.

4. The LNHA is responsible for the POC implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The dumpster will be checked twice daily by the dietary department; confirming garbage containment and a closed dumpster door x eight (8) weeks then weekly thereafter x six (6) months. These dumpster checks shall be documented; b) The Food Service Manager will conduct a refuse audit monthly x two (2) months then quarterly x one (1) year which includes the monitoring of refuse management. Variances will be addressed promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.

F 842 SS=D — Completion date: 6/25/18

Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is

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F 842	Continued From page 74	F 842		

resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 75 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to ensure accurate medical records for 1 Resident of 18 in the survey sample. (Resident #36). The Facility Staff Failed to ensure Resident #36's April and May 2018 Treatment Administration Record was complete and accurate. The findings included: Resident #36 was admitted to the facility on 10/28/16. Diagnoses for Resident #36 included but are not limited to Alzheimer's disease and Cervical Fracture.	F 842	F842 1. The DON met with currently employed nurses assigned to Resident #36 on 4-18-18 day shift and 5-3-18 and 5-5-18 evening shift to explore the documentation variances and to further understand documentation of treatment administration practices. The nurses were and re-educated to documentation requirements. 2. A review of May 2018 Treatment Administration Records (TAR□s) was conducted for all current residents; ensuring consistent documentation for all ordered treatments. Variances noted	

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F 842	Continued From page 76 Resident #36's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/4/16 coded Resident #36 with a BIMS (Brief Interview for Mental Status) score of 8 out of a possible 15 indicating a moderate cognitive impairment. On 5/16/18 at approximately 2 PM, a Review of Resident #36's Treatment Administrator Record (TAR) for April and May 2018 showed the following omissions for signatures of the nurse. April 2018 TAR Check C-Collar for Protective foam Padding and Positioning every shift for wound healing and skin protection: Nurse initial omissions were noted for the following dates: 4/18/18 Day shift May 2019 TAR Check C-Collar for Protective foam Padding and Positioning every shift for wound healing and skin protection: Nurse omissions were noted for the following dates: 5/3/18 Evening Shift 5/5/18 Evening Shift Apply zinc protestant to buttock sacrum and groin area every shift after each incontinent episode and prn every shift Nurse omissions were noted for the following dates: 5/3/18 Evening shift 5/3/18 Evening Shift An interview with the Director of Clinical Services (DCS) on 3/17/18 at approximately 2:30 PM was conducted. The DCS stated that it was her	F 842	were addressed with assigned nurses and re education was delivered. 3. The facility□s Medication/Treatment Administration policy was reviewed for clarity. No revisions were needed. A meeting was held with the licensed nurses; confirming his/her understanding of the policy and expectation of documenting treatments as ordered and performed. All licensed nurses were re educated to the policy and expectation. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) Weekly checks of TAR□s by the UM or DON shall occur x two (2) months; ensuring documentation compliance; b) Point Click Care (PCC) dashboard reviews of treatments not administered or signed off will be conducted weekly x two (2) months by the UM or DON; ensuring documentation compliance; c) Chart Audits will be performed by the UM or DON for up to 10% of the residents monthly x two (2) months then quarterly x six (6) months (which includes a review of the TAR□s) confirming compliance. Variances will be addressed promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.	

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F 842	Continued From page 77 expectation for nurses to complete documentation after it is completed. The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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	F 880		6/25/18

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F 880	Continued From page 78 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 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 observation, resident interview, staff interview, facility documentation review, clinical	F 880	F880 1. Resident #4 remains at baseline. Nurse	

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F 880	Continued From page 79 record review, the facility failed to ensure infection control measures for sanitizing the glucometer prior and after use to prevent the potential transmission of infection for 1 Resident of 18 (Resident #4) was performed. The findings included: Resident #4 was admitted to the facility on 10/23/17. Diagnosis for Resident #4 include but are not limited to Diabetes Mellitus. Resident #4's Admission Assessment with an Assessment Reference Date of 10/30/17 coded Resident #4 with a BIMS (Brief Interview for Mental Status) of 15 out of 15 indication no cognition impairment. Resident #4 required extensive assistance with Dressing, Bed Mobility, Transfers, Toilet Use, and Personal Hygiene. Resident #4's Physician Orders documented the following: 10/23/17 Humalog Solution 100 Unit/Milliliter Inject as per sliding scale: subcutaneously three times a day for blood sugar if 201-250 = 2 units 251-300 = 4 units 301-350 = 6 units 351- 400 = 8 units 401-450 = 10 units Resident #4's Current 5-2018 Person Centered Care Plan documented the following focus area: Focus Area: Alteration in blood Glucoses Goal: Resident's blood glucoses will be within normal limits Interventions: Blood glucose monitoring per MD	F 880	#11 was re-educated to the glucometer cleaning policy. 2. All residents who receive glucose finger sticks have the potential to be affected. 3. A review of the facility□s Equipment Cleaning policy (which includes glucometers) was reviewed. No revisions are needed. Glucometer specific manufacturer cleaning guidelines were also reviewed to ensure available cleaning supplies were in concert with said guidelines. No variances were noted. All licensed nursing staff will be re educated to the glucometer cleaning before and after each use and will be re assessed using a glucometer competency check. Glucometer competencies are part of licensed nurse orientation. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The UM or DON will conduct weekly glucometer checks with nurses assigned to perform the same x one (1) months then monthly x two (2) months; confirming compliance with the cleaning policy and manufacturer guidelines; b) The DON will conduct the Environmental Rounds and Safety Audit monthly x two (2) months then quarterly x six (6) months which requires the observation of the glucometer and related documentation for cleaning; ensuring compliance with policy and expectations. Variances will be addressed promptly.	

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F 880	Continued From page 80 order prior to sliding scale On 5/15/18 at approximately 12:35 PM, during the medication task, Licensed Practical Nurse (LPN) #11 was observed obtaining Resident #4's blood glucose reading. LPN #11 stated she cleaned the glucometer with an alcohol wipe prior to testing Resident #4's glucose. LPN #11 did the glucometer test and returned the glucometer to the medication drawer. LPN #11 was observed to not sanitize the glucometer prior to or after performing the test. LPN #11, did not place Resident #4's glucometer in a bag to be used for her only until after the surveyor asked if she would normally place the glucometer in a bag. LPN #11 stated that she did not have any type of bag. LPN #11 was observed later with a Blood Pressure bag walking to the medication cart and she stated that she had obtained a bag for the glucometer. The Director of Clinical Services (DCS) on 5/17/18 at approximately 4:00 PM stated that it would be her expectation for a nurse to sanitize the glucometer before and after use. The EvenCare G3 Blood Glucose Monitoring system User Guide pages 46 through 47 documented the following: The EvenCare G3 Meter should be cleaned and disinfected between each patient. The following products have been approved for cleaning and disinfecting the EvenCare G3 Meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach	F 880	The QAA committee will determine the frequency of continued ongoing monitoring thereafter.	

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Medline Micro Kill Disinfecting deodorizing, Cleaning wipes with alcohol
Clorox Healthcare Bleach Germicidal and Disinfectant Wipes
Medline Micro Kill Bleach Germicidal Bleach wipes
Other EPA registered wipes may be used for disinfecting the EvenCare G3 system however; these wipes have not been validated and could affect the performance of your meter

Resident #4 has a glucometer designated for her; however, Resident #4 requires the nurses to perform the test. Resident #4 is dependent on the nurses to adhere to standard infection control practices.

The Facility Policy with a revision date of 2014, titled, "Cleaning and Disinfection of Resident-Care Items and Equipment", documented the following:

"The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care:
a. Critical Items: consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue or the vascular system are considered critical items and must be sterile.
d. Reusable items are cleaned and disinfected or sterilized between residents (durable medical equipment)

The Center for Disease Control web site (https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html) documents the following:

Monitoring of blood glucose levels is frequently

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performed to guide therapy for persons with diabetes. Blood glucose monitoring and insulin administration can be accomplished in two ways: self-monitoring of blood glucose and insulin administration, where the individual performs all steps of the testing and insulin administration themselves, and assisted monitoring of blood glucose and insulin administration, where another person assists with or performs testing and insulin administration for an individual.

Unsafe Practices during Blood Glucose Monitoring and Insulin Administration

An under appreciated risk of blood glucose testing is the opportunity for exposure to bloodborne viruses (HBV, hepatitis C virus, and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters, finger stick devices, insulin pens) are shared.

Outbreaks of hepatitis B virus (HBV) infection associated with blood glucose monitoring have been identified with increasing regularity, particularly in long-term care settings, such as nursing homes and assisted living facilities, where residents often require assistance with monitoring of blood glucose levels and/or insulin administration. In the last 10 years, alone, there have been at least 15 outbreaks of HBV infection associated with providers failing to follow basic principles of infection control when assisting with blood glucose monitoring. Due to under-reporting and under recognition of acute infection, the number of outbreaks due to unsafe diabetes care practices identified to date are likely an underestimate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING ______ B. WING ______	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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
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Although the majority of these outbreaks have been reported in long-term care settings, the risk of infection is present in any setting where blood glucose monitoring equipment is shared or those assisting with blood glucose monitoring and/or insulin administration fail to follow basic principles of infection control. For example, at a health fair in New Mexico in 2010, dozens of attendees were potentially exposed to bloodborne viruses when finger stick devices were inappropriately reused for multiple persons to conduct diabetes screening. Additionally, at a hospital in Texas in 2009, more than 2,000 persons were notified and recommended to undergo testing for bloodborne viruses after individual insulin pens were used for multiple persons.

Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include:

· Using finger stick devices for more than one person
· Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses
· Using insulin pens for more than one person
· Failing to change gloves and perform hand hygiene between fingerstick procedures

The facility administration was informed of the findings during a pre-exit-briefing on 5/17/18 at approximately 5:45 PM. The facility did not present any further information about the findings.