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	495297	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/14/18 through 11/16/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/14/18 through 11/16/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 34 current Resident reviews (Residents #19, #361, #362, #2, #360, #72, # 13, #93, #95, #32, #87, #26, #15, #48, #42, #107, #1, #411, #49, #29, #410, #96, #59, #46, #36, #460, #64, #97, #10, #5, #68, #106, #23 and # 14) and four closed record reviews (Residents #81, #77, #58 and # 88.)	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical	F 558	The statements included are not an admission and do not constitute	12/18/18

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

Electronically Signed | 12/05/2018

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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F 558	Continued From page 1 record review, it was determined that the facility staff failed to ensure accommodation of resident needs for one of 38 residents in the survey sample, Resident # 46. The facility staff failed to ensure Resident #46's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. The findings include: Resident # 46 was admitted to the facility on 03/03/17 and a readmission on 10/15/18 with diagnoses that included but were not limited to rheumatoid arthritis (1), dysphagia (2), anxiety (3) and hypertension (4). Resident # 46's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/18, coded Resident # 46 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 46 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. 11/14/18, at 3:40 p.m., an interview was conducted with Resident #46. Resident #46 stated the call bell is not always available. "They wrap it around the bed rail (upper bed rail) and I can't reach it." When asked to find and activate her call bell during the interview, Resident # 46 searched her bed and was unable to locate it. Resident # 46 stated, "I don't know where it is. I have arthritis in my shoulders and it is hard to reach back and above my head to reach the call	F 558	agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F-558 1. Resident #46□s call bell was checked for placement, returned within residents reach, and clip replaced to ensure it remains within reach of resident. 2. All residents are at risk. 3. The Staff Development Coordinator or designee will educate all staff members on ensuring call bell□s are placed within the reach of all residents. 4. DON or designee will audit 100% of residents for call bell placement 2x daily for one week, then 1x daily, 5x per week for 4 weeks, then review findings in following QA meeting. 5. Date of Compliance: 12.18.2018.	

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bell. Sometimes I have to yell for help."
Observation of Resident # 46's call bell during the interview revealed it was lying on the floor under Resident # 46's bed.

On 11/16/18 at 10:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 3.
When asked to describe the procedure to ensure a call bell is accessible for the resident, LPN # 3 stated, "Make sure it is across their bed or within reach. During regular rounds, every two hours, and when staff are in and out of the room staff should check and make sure it is with the resident's reach." When asked why it was important to ensure the resident's call bell is always accessible, LPN # 3 stated, "At any given moment they may need us and it is the best way to get our attention and for safety, so they don't try to get out of bed and fall." When informed of the observation of Resident # 46's call bell, LPN # 3 stated that it should have been checked and placed within her reach.

On 11/16/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3 regional consultant, ASM # 4 regional consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

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F 558	Continued From page 3 (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 558		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. 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	F 623		12/18/18

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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.

§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

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F 623	Continued From page 5 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 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 staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident, resident representative, and ombudsman upon transfer to	F 623	F-623 1. Resident #36, #5, #95, #72, #87, #49, and #46; all Resident Responsible Parties and the Ombudsman have since received	

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F 623	Continued From page 6 the hospital for seven of 38 residents in the survey sample: Residents #36, #5, #95, #72, #87, #49, and #46. 1. The facility staff failed to provide written documentation to the resident and/or resident representative upon transfer to the hospital on 8/20/18, as well as the Ombudsman, for a facility initiated transfer on 9/30/18 for Resident #36. 2. The facility staff failed to provide written documentation to the resident and/or resident representative upon transfer to the hospital on 7/21/18 for Resident #5. 3. The facility staff failed to provide Resident #95 or the resident's representative (RR) and the ombudsman with written documentation of a facility initiated transfer dated 8/16/18 and 9/7/18. 4. The facility staff failed to provide written notification of the 09/22/2018 hospital transfer to Resident #72, and or the resident's responsible party and to the Long Term Care Ombudsman. 5. The facility staff failed to provide written notification of 10/20/2018 Hospital transfer to Resident #87 and or the residents responsible Party. 6. The facility staff failed to provide Resident # 49 or the resident's representative and the ombudsman with written notification when the resident was transferred to the hospital on 09/23/18. 7. The facility staff failed to provide Resident # 46 or the resident's representative with written notification when the resident was transferred to	F 623	written notification of a facility or hospital transfer(s) respectively. 2. All resident□s requiring facility or hospital transfer are at risk. 3. SDC or designee to educate discharge planning staff on the requirements of written notification upon facility or hospital transfer. 4. Administrator or designee will audit 100% of facility or hospital transfers for written notification of transfer to Resident or Resident Responsible Party and Ombudsman 2x weekly for 4 weeks, then review findings in following QA meeting. 5. Date of Compliance: 12.18.2018.	

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the hospital on 07/20/18.

The findings include:

1. The facility staff failed to provide written documentation to the resident and/or resident representative upon transfer to the hospital on 8/20/18, as well as the Ombudsman, for a facility initiated transfer on 9/30/18 for Resident #36.

Resident #36 was admitted to the facility on 12/13/17, with a most recent readmission of 11/5/18, with diagnoses that included but were not limited to: amputation of left leg above the knee, diabetes, heart failure, high blood pressure, heart attack, respiratory failure, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 9/14/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating he has no cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one or more staff members for bed mobility, transfers, dressing, toileting, and personal hygiene.

The nurse's note dated 8/20/18 at 11:06 a.m. documented in part, "Wound assessment has been completed ...left heel, Progress: deteriorating."

The nurse's note dated 8/20/18 at 5:39 p.m. documented in part, "Change of condition are: Fever [sic] wound or ulcer ...vital signs P (pulse) 90, R (respiration rate) 18, T (temperature) 101.8."

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The physician's order dated 8/20/18, time not documented, "Send resident to hospital."

The nurse's notes dated 9/30/18 at 10:45 p.m. documented in part, "Resident was sent out to [Hospital's name] tonight for respiratory distress. Resident complained of SOB (shortness of breath) with noted wheezing present. Resident denied having chest tightness or any other pain. Profusely sweating. Vital signs BP (blood pressure) 187/106, O2 (oxygen) saturations 92% on 3 liters [of oxygen]. Pulse 92. No fever noted. MD (medical doctor) [MD's name] consulted for transfer of resident. RP [responsible party] notified."

On 11/15/18 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked to describe the process for notifying the resident or responsible representative, LPN #6 stated she tells the resident if they are their own responsible party or she calls the responsible party listed in the clinical record. She stated they print the face sheet, laboratory reports, and progress notes, which are sent with the resident to the hospital. When asked if she provided written notification to the resident or responsible representative, LPN #6 stated "No."

On 11/15/18, at approximately 4:00 p.m., ASM (administrative staff member) #1, the administrator, confirmed that the residents' representatives are notified via phone when residents are transferred to the hospital but written notification regarding the transfer is not provided. When asked how the facility verifies that the Ombudsman receives this information, ASM #1 stated she would need to check.

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ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, regional consultant, and ASM #4, regional consultant, were made aware of the above findings on 11/15/18 at 5:38 p.m.

On 11/16/18 at approximately 8:05 a.m., a telephone interview was conducted with OSM (other staff member) #3, the Ombudsman, regarding the notification of the facility's initiated transfers of residents to the hospital for the period of July 1, 2018 through October 31, 2018. During the telephone interview a list of resident's who had facility initiated transfers to the hospital was provided by the surveyors to OSM #3. On 11/16/18 at approximately 9:02 a.m., a facsimile was received from OSM #3. The facsimile documented that all of the facility initiated transfers of residents to the hospital for the period of July 1, 2018 through October 31, 2018 were verified "except for September." OSM #3 documented that she had not received notification of Resident #36's September 30, 2018 transfer to the hospital.

On 11/16/18 at approximately 9:21 a.m., an interview was conducted with OSM (other staff member) #5, director of discharge planning regarding notification to the Ombudsman of a resident's transfer to a hospital. OSM #5 stated, "At the end of the month or beginning of next month, I print unplanned and planned discharges or transfers and mail them by postal service." When asked if she verifies the accuracy and that, the ombudsman received the list of unplanned and planned discharges or transfers, OSM #5 stated, "I call and ask the ombudsman if she received the list or if she is here (in the facility) she will tell me if she received the list." When

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asked if she verifies the names of transfers on the list, OSM # 5 stated, "No."

The facility's policy "Notice of Transfer/Discharge" documents in part, "4. Provide proper advance notification of the transfer/discharge to the patient and family member/legal representative utilizing the [Corporate Name] Notice of Transfer/Discharge form ...ii. If a transfer/discharge is involuntary and for the following reasons, notification shall be made as soon as reasonably possible: 1) The patient's welfare and needs cannot be met in the Center." The policy further documents "Send designated copies of the completed [Corporation name] Notice of Transfer/Discharge form to each of those specified on the form (which includes the Ombudsman)."

No further information was provided prior to exit.

2. The facility staff failed to provide written documentation to the resident and/or resident representative upon transfer to the hospital on 7/21/18 for Resident #5.

Resident #5 was admitted to the facility on 2/23/18, with a most recent readmission of 7/27/18, with diagnoses that included but were not limited to: Spastic quadriplegic cerebral palsy [the most severe form of cerebral palsy and is often associated with moderate-to-severe intellectual disability. It is caused by widespread damage to the brain or significant brain malformations. Patients will often have severe stiffness in their limbs but a floppy neck. They are rarely able to walk. Speaking and being understood are difficult. (1)], difficulty-swallowing,

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seizures, tube feeds [liquid supplement that is delivered via a soft, plastic tube placed into the stomach. It delivers nutrition (food) and medicines for patients who have difficulty with chewing and swallowing. (2)], and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/07/18, coded the resident as rarely/never being able to be understood as well as rarely/never understanding others. Resident #5 was documented as having severe impairment for daily decision-making. The resident was coded as being totally dependent on at least one staff member for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting, and personal hygiene.

The nurse's note dated 7/21/18 at 10:35 p.m. documented in part, "Patient sent to ER (emergency room) per brother [responsible representative's name] request. MD (medical doctor) [MD's name] notified ...Patient began vomiting clear fluid in presence of mother ...Patient blood pressure was 118/83, pulse 115, oxygen 93-94%, resp (respirations) 22 ...Patient began to get restless after writer suctioned her ...She began to breath heavily."

On 11/15/18 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked to describe the process for notifying the resident or responsible representative, LPN #6 stated she tells the resident if they are their own responsible party or she calls the responsible party listed in the clinical record. She stated they print the face sheet, laboratory reports, and progress notes, which are sent with the resident

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to the hospital. When asked if she provided written notification to the resident or responsible representative, LPN #6 stated "No."

On 11/15/18, at approximately 4:00 p.m., ASM (administrative staff member) #1, the administrator, confirmed that the residents' representatives are notified via phone when residents are transferred to the hospital but written notification regarding the transfer is not provided.

ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, regional consultant, and ASM #4, regional consultant, were made aware of the above findings on 11/15/18 at 5:38 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=spastic+quadriplegic+cerebral+palsy&_ga=2.158964734.519186019.1543242901-2097824294.1523895640

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000333.htm

2. The facility staff failed to provide Resident #95 or the resident's representative (RP) and the ombudsman with written documentation of a facility initiated transfers on 8/16/18 and 9/7/18.

Resident #95 was admitted to the facility on 8/11/18 with a readmission date of 10/24/18.

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Diagnoses included but were not limited to: diabetes, spinal stenosis (1), anemia (2) and syncope with collapse (3).

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 10/24/18 coded the resident as having a score of 13 of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions.

Review of Resident #95's clinical record revealed that he had been sent to the hospital on 8/16/18. A nursing note dated 8/16/18 at 10:54 a.m. documented, "Patient was sent to the E.R. (emergency room)."

Review of Resident #95's clinical record revealed that he had been sent to the hospital on 9/7/18. A nursing note dated 9/7/18 at 11:00 a.m. documented, "Resident complained of chest pains 5 out of 10 pain level. Vital signs within normal limits with no signs or symptoms of breath [sic] or sweating or cyanosis noted. Wife present at bedside and wanting [sic] to go to the hospital. M.D. (medical doctor) aware and ordered to send resident to the hospital."

Further review of the clinical record failed to evidence documentation that Resident #95, the RP (responsible party) or the Ombudsman were given written notice regarding the facility initiated transfer dated 8/16/18 or for facility initiated transfer dated 9/7/18.

On 11/15/18 at approximately 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked what

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documentation is required when a resident goes to the hospital, LPN #6 stated "We fill out an e interact form that includes face sheet, care goals, advance directive, vitals and a nursing note. We also print out labs (laboratory studies) and send this as a packet to the hospital." When asked if staff provide written notification to the resident or the RP when a resident is hospitalized, LPN #6 replied "No." When asked if written notification was sent to the Ombudsman regarding Resident #95's hospital transfer dated 8/16/18 or 9/7/18, LPN #6 responded, "I don't think so."

On 11/15/18 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 was asked if the resident or residents' representatives were notified in writing of a facility initiated hospital transfer, ASM #1 replied, "The resident or residents' representatives were notified via phone when residents are transferred to the hospital, but written notification regarding the transfer is not provided."

On 11/16/18 at approximately 8:05 a.m., a telephone interview was conducted with OSM (other staff member) #3, the Ombudsman, regarding the notification of the facility's initiated transfers of residents to the hospital for the period of July 1, 2018 through October 31, 2018. During the telephone interview a list of resident's who had facility initiated transfers to the hospital was provided by the surveyors to OSM #3. On 11/16/18 at approximately 9:02 a.m., a facsimile was received from OSM #3. The facsimile documented that all of the facility initiated transfers of residents to the hospital for the period of July 1, 2018 through October 31, 2018 were verified "except for September." The facsimile

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documented the Ombudsman was not notified of a facility initiated hospital transfer on 8/16/18 and 9/7/18, for Resident #95.

On 11/16/18 at approximately 9:21 a.m., an interview was conducted with OSM #5, the Social Worker. OSM #5 was asked does the facility send written notification to the Ombudsman for hospital transfers, OSM #5 replied, "At the end of the month or the beginning of the next month, we print out unplanned and planned discharges, and mail them to the Ombudsman." When asked does the facility have evidence of written notification for Resident #95's facility initiate hospital transfer dated 8/16/18 or 9/7/18, OSM #5 replied, "I do not, the ombudsman verifies that she got a list but not specific residents."

On 11/16/18 at approximately 1:00 p.m., ASM #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings.

No further information was provided prior to exit.

1. A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

2. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body. This information was obtained from the website:

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https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=anemia&_ga=2.71282640.1704263304.1542638661-1154288035.1542638661

3. Fainting is a temporary loss of consciousness. If you're about to faint, you'll feel dizzy, lightheaded, or nauseous. Your field of vision may "white out" or "black out." Your skin may be cold and clammy. You lose muscle control at the same time, and may fall down. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=syncope.
4. The facility staff failed to provide written notification of the 09/22/2018 hospital transfer to Resident #72, and or the resident's responsible party and to the Long Term Care Ombudsman.

Resident #72 was initially admitted on 09/08/2018, and her most recent re-admission was 09/30/2018. Resident #72's diagnoses included, but were not limited to, Anemia (a condition causing the blood to carry less oxygen), Hypertension (elevated blood pressure), Diabetes Mellitus Type II (a condition causing elevated levels of sugar in the blood), Stroke, Hemiplegia (one-sided weakness or paralysis), and Depression. Resident #72's most recent Minimum Data Set (MDS) assessment was a 30-day assessment with an assessment reference date (ARD) of 10/21/2018. Resident #72 was coded as rarely or never understood. The Staff Assessment for Mental Status coded Resident #72 as 3 - Severely Impaired. Resident #72 was coded as requiring total assistance of two or more people for transfer and ambulation

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and as requiring total assistance of one person for bed mobility, dressing, eating, toileting, and hygiene.

On 11/14/2018, a review of Resident #72's record was conducted. It was noted that Resident #72 was discharged to the Hospital on 09/22/2018 for suspected anemia. Upon examination of the medical record, no documentation could be located evidencing that the facility had provided Resident #72 or their Responsible Party (RP) with written notice of the transfer. Furthermore, no evidence could be found of the facility notifying the Long Term Care Ombudsman of the transfer.

On 11/15/2018 at 3:55p.m., an interview was conducted with Licensed Practical Nurse (LPN) #6. When asked to describe the process for when a Resident goes to the hospital, LPN #6 stated that the RP (responsible party) and Medical Doctor (MD) are notified, as well as the Supervisor. When asked how the RP is notified, LPN #6 stated that they speak with the resident directly if they are their own RP, or call the RP on the phone if not. When asked if staff provide a written notification to the resident or RP, LPN #6 stated "No".

On 11/15/18 at approximately 4:00 p.m., ASM (administrative staff member) #1 (the administrator) confirmed residents' representatives are notified via phone when residents are transferred to the hospital but written notification regarding the transfer is not provided.

On 11/16/18 at approximately 8:05 a.m., a telephone interview was conducted with OSM (other staff member) # 3, the Long Term Care

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Ombudsman, regarding notification to the Ombudsman of facility initiated transfers of residents to the hospital for the period of July 1, 2018 through October 31, 2018. During the telephone interview, a list of residents who had a facility-initiated transfer to a hospital was provided to OSM #3 by surveyors.

On 11/16/18 at approximately 9:02 a.m., a facsimile was received from OSM # 3. The facsimile documented that all of the facility-initiated transfers of residents to a hospital for the period of July 1, 2018 through October 31, 2018 were verified "except for September." OSM #3 documented that she had not received notification of Resident #72's September 22, 2018 transfer to the hospital.

The Administrator, ASM (administrative staff member) #1 and ASM #2, the Director of Nursing were informed of the findings at the end of day meeting on 11/16/2018. No further information was provided.

5. The facility staff failed to provide written notification of 10/20/2018 Hospital transfer to Resident #87 and or the residents responsible Party.

Resident #87 was initially admitted on 03/26/2018, and his most recent re-admission was 10/26/2018. Resident #87's diagnoses included, but were not limited to, Hypertension (elevated blood pressure), Quadriplegia (weakness or paralysis of all 4 limbs), and Traumatic Brain Injury. Resident #87's most recent Minimum Data Set (MDS) assessment was an Entry Tracking Assessment with an assessment reference date (ARD) of 10/26/2018.

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Resident #87 was coded as rarely or never understood. The Staff Assessment for Mental Status coded Resident #87 as three - Severely Impaired.

On 11/14/2018, a review of Resident #87's record was conducted. It was noted that Resident #87 was discharged to the Hospital on 10/20/2018. Upon examination of the medical record, no documentation could be located evidencing that the facility had provided Resident #87 or their Responsible Party (RP) with written notice of the transfer. Furthermore, no evidence could be found of the facility notifying the Long Term Care Ombudsman of the Transfer.

On 11/15/2018 at 3:55p.m., an interview was conducted with Licensed Practical Nurse (LPN) #6. When asked to describe the process for when a Resident goes to the hospital, LPN #6 stated that the RP (responsible party) and Medical Doctor (MD) are notified, as well as the Supervisor. When asked how the RP is notified, LPN #6 stated that they speak with the resident directly if they are their own RP, or call the RP on the phone if not. When asked if staff provide a written notification to the resident or RP, LPN #6 stated "No".

On 11/15/18 at approximately 4:00 p.m., ASM (administrative staff member) #1 (the administrator) confirmed residents' representatives are notified via phone when residents are transferred to the hospital but written notification regarding the transfer is not provided.

The Administrator, ASM #1 and ASM #2, the Director of Nursing were informed of the findings

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at the end of day meeting on 11/16/2018. No further information was provided.

6. The facility staff failed to provide Resident # 49 or the resident's representative and the ombudsman with written notification when the resident was transferred to the hospital on 09/23/18.

Resident # 49 was admitted to the facility on 11/21/17 and a readmission on 09/26/18 with diagnoses that included but were not limited to osteoarthritis (1), hemiplegia (2), anxiety (3) and chronic obstructive pulmonary disease (4).

Resident # 49's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/28/18, coded Resident # 49 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 49 dated 09/16/2018 documented, "14:53 (2:53 p.m.) Patient complained chest pain that radiated to her back. Pain in both arms and legs. BP (blood pressure) 177/78 (177 over 78). She complained of SOB (shortness of breath). Lungs sounds clear in all quadrants, O2 (oxygen) 98% (percent). MD (medical doctor) (Name of Doctor) order she be sent out. Patient transported to (Name of Hospital)."

On 1/15/18 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 6. When asked if written notification for facility-initiated transfers to the hospital are provided to the resident or the resident's

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representative, LPN # 6 stated, "We notify the responsible party, physician and supervisor." When asked how they were notified, LPN # 6 stated, "We tell them if resident is their own responsible party and call the responsible party and physician." When asked if they provide a written notification to resident or resident representative LPN # 6 stated, "No."

On 11/15/18 at approximately 4:00 p.m., ASM (administrative staff member) #1 (the administrator) confirmed residents' representatives are notified via phone when residents are transferred to the hospital but written notification regarding the transfer is not provided.

On 11/16/18 at approximately 8:05 a.m., a telephone interview was conducted with OSM (other staff member) #3, the Ombudsman, regarding the notification of the facility's initiated transfers of residents to the hospital for the period of July 1, 2018 through October 31, 2018. During the telephone interview a list of resident's who had facility initiated transfers to the hospital was provided by the surveyors to OSM #3. On 11/16/18 at approximately 9:02 a.m., a facsimile was received from OSM #3. The facsimile documented that all of the facility initiated transfers of residents to the hospital for the period of July 1, 2018 through October 31, 2018 were verified "except for September." OSM #3 documented that she had not received notification of Resident #49's September 23, 2018 transfer to the hospital.

On 11/16/18 at approximately 9:21 a.m., an interview was conducted with OSM (other staff member) # 5, director of discharge planning

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regarding the notification to the Ombudsman of a resident's transfer to a hospital. OSM # 5 stated, "At the end of the month or beginning of next month, I print unplanned and planned discharges or transfers and mail them by postal service." When asked if she verifies the accuracy and that the ombudsman received the list of unplanned and planned discharges or transfers, OSM # 5 stated she calls and asks the ombudsman if she received the list or if she is here (in the facility) she will tell me if she received the list." When asked if she verifies the names of transfers on the list, OSM # 5 stated "no".

On 11/16/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3 regional consultant, ASM # 4 regional consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.

(2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website:

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https://medlineplus.gov/paralysis.html.

(3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

7. The facility staff failed to provide Resident # 46 or the resident's representative with written notification when the resident was transferred to the hospital on 07/20/18.

Resident # 46 was admitted to the facility on 03/03/17 and a readmission on 10/15/18 with diagnoses that included but were not limited to rheumatoid arthritis (1), dysphagia (2), anxiety (3) and hypertension (4).

Resident # 46's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/18, coded Resident # 46 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 49 dated 07/16/2018 documented, "Change of Condition. 17:51 (5:51 p.m.) Resident's lab (laboratory) results sent to (Name of Doctor) and he ordered that the resident be sent to ER (emergency room). Resident was informed and refused at first. Called unit manager then DON

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(director of nursing) and myself and another nurse went back to the room and asked resident again about going to ER and this time she agreed to go -911 has been called, made call to (Name of Responsible Party) message left on home phone, cell phone can not (Sic.) accept message, mailbox is full."

On 1/15/18 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 6. When asked if written notification for facility-initiated transfers to the hospital are provided to the resident or the resident's representative, LPN # 6 stated, "We notify the responsible party, physician and supervisor." When asked how they were notified, LPN # 6 stated, "We tell them if resident is their own responsible party and call the responsible party and physician." When asked if they provide a written notification to resident or resident representative LPN # 6 stated, "No."

On 11/15/18 at approximately 4:00 p.m., ASM (administrative staff member) #1 (the administrator) confirmed residents' representatives are notified via phone when residents are transferred to the hospital but written notification regarding the transfer is not provided.

On 11/16/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3 regional consultant, ASM # 4 regional consultant, were made aware of the findings.

No further information was provided prior to exit.

References:

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F 623	Continued From page 25 (1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	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; (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	F 625		12/18/18

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F 625	Continued From page 26 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 staff interview, clinical record review, and facility document review, it was determined that facility staff failed to evidence that a written bed hold notification was provided upon a facility initiated hospital transfer for five of 38 residents in the survey sample, Resident #36, 95, 87, 49, and 46. 1. The facility staff failed to provide Resident #36 with written notification of the bed hold policy for facility initiated transfers to the hospital on 8/20/18 and 9/30/18. 2. The facility staff failed to provide Resident #95 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 8/16/18 and 9/7/18. 3. The facility Staff failed to provide Resident #87 and or the responsible party with written notice of the bed hold policy at the time of the 10/20/2018 Hospital transfer. 4. The facility staff failed to provide Resident # 49	F 625	F-625 1. Resident #36, #95, #87, #49, and #46 are currently in the center. 2. All residents requiring facility or hospital transfer are at risk. 3. SDC or designee to educate licensed nursing staff on providing the written notification of bed-hold policy at the time of transfer. 4. DON or designee will audit 100% of resident□s requiring hospitalization or therapeutic leave for written notice of bed hold policy daily for 2 weeks, then 5x weekly for two weeks, then review findings in following QA meeting. 5. Date of Compliance- 12.18.2018.	

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or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/23/18.

5. The facility staff failed to provide Resident # 46 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 07/20/18.

The findings include:

1. The facility staff failed to provide Resident #36 with written notification of the bed hold policy for facility initiated transfers to the hospital on 8/20/18 and 9/30/18.

Resident #36 was admitted to the facility on 12/13/17, with a most recent readmission of 11/5/18, with diagnoses that included but were not limited to: amputation of left leg above the knee, diabetes, heart failure, high blood pressure, heart attack, respiratory failure, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 9/14/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating he has no cognitive impairment for daily decision making.

The nurse's note dated 8/20/18 at 11:06 a.m. documented in part, "Wound assessment has been completed ...left heel, Progress: deteriorating."

The nurse's note dated 8/20/18 at 5:39 p.m.

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documented in part, "Change of condition are: Fever [sic] wound or ulcer ...vital signs P (pulse) 90, R (respiration rate) 18, T (temperature) 101.8."

The physician's order dated 8/20/18, time not documented, stated, "Send resident to hospital."

The nurse's notes dated 9/30/18 at 10:45 p.m. documented in part, "Resident was sent out to [Hospital's name] tonight for respiratory distress. Resident complained of SOB (shortness of breath) with noted wheezing present. Resident denied having chest tightness or any other pain. Profusely sweating. Vital signs BP (blood pressure) 187/106, O2 (oxygen) saturations 92% on 3 liters [of oxygen]. Pulse 92. No fever noted. MD (medical doctor) [MD's name] consulted for transfer of resident. RP [responsible party] notified."

Further review of the clinical record failed to reveal any documentation evidencing the written bed hold policy was provided to the resident or responsible party at the time of transfer to the hospital on 9/30/18.

On 11/15/18 at 4:10 p.m., an interview was conducted with OSM (other staff member) #4, the director of admissions. OSM #4 stated once the facility is aware that the resident has been admitted to the hospital, she calls the resident or the resident's responsible representative to see if they want to hold the bed. If the resident or the resident's responsible party wishes to keep the same bed (or room), they must agree to pay for a bed hold. When asked if written bed hold information is provided to the resident or responsible party, OSM #4 stated, "Only if the

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resident wants to keep the same bed."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, regional consultant, and ASM #4, regional consultant, were made aware of the above findings on 11/15/18 at 5:38 p.m.

A review of the facility's "Bed Reserve" policy, failed to evidence that the resident and/or responsible party are notified in writing of the bed hold policy upon transfer to a facility.

No further information was provided prior to exit.
2. The facility staff failed to provide Resident #95 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 8/16/18 and 9/7/18.

Resident #95 was admitted to the facility on 8/11/18 with a readmission date of 10/24/18. Diagnoses included but were not limited to: diabetes, spinal stenosis (1), anemia (2) and syncope with collapse (3).

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 10/24/18 coded the resident as having a score of 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions.

Review of Resident #95's clinical record revealed that he had been sent to the hospital on 8/16/18. A nursing note dated 8/16/18 at 10:54 a.m. documented, "Patient was sent to the E.R. (emergency room)."

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Review of Resident #95's clinical record revealed he was sent to the hospital on 9/7/18. A nursing note dated 9/7/18 at 11:00 a.m. documented, "Resident complained of chest pains 5 out of 10 pain level. Vital signs within normal limits with no signs or symptoms of breath [sic] or sweating or cyanosis noted. Wife present at bedside and wanting [sic] to go to the hospital. M.D. (medical doctor) aware and ordered to send resident to the hospital."

Further review of the clinical record failed to evidence that written notification of the bed-hold policy was provided to Resident #95 or the resident's representative for the facility initiated hospital transfers on 8/16/18 or 9/7/18.

On 11/15/18 at approximately 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) #6, regarding the documentation provided to residents' when a resident goes to the hospital. LPN #6 stated "We fill out an e interact form that includes face sheet, care goals, advance directive, vitals and a nursing note. We also print out labs (laboratory tests) and send to this is a packet to the hospital." When asked if a copy of the written bed hold policy is provided to the resident and/ or the residents' representative upon a facility initiated hospital transfer, LPN #6 replied "No."

On 11/15/18 at 4:09 p.m., an interview was conducted with OSM (other staff member) #4, the Admissions Director. When asked if residents and/or their representatives are provided written information regarding the bed hold policy when a resident is discharged to the hospital, OSM #4 replied, "I do call the family and ask about a bed hold and if they want the same bed they fill out a

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form and pay a fee. I usually don't give them a form when they are transferred."

On 11/16/18 at approximately 1:00 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings.

No further information was provided prior to exit.

1. A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

2. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=anemia&_ga=2.71282640.1704263304.1542638661-1154288035.1542638661

3. Fainting is a temporary loss of consciousness. If you're about to faint, you'll feel dizzy, lightheaded, or nauseous. Your field of vision may "white out" or "black out." Your skin may be cold and clammy. You lose muscle control at the same time, and may fall down. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

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meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=syncope.

3. The facility Staff failed to provide Resident #87 and or the responsible party with written notice of the bed hold policy at the time of the 10/20/2018 Hospital transfer.

Resident #87 was initially admitted on 03/26/2018, and his most recent re-admission was 10/26/2018. Resident #87's diagnoses included, but were not limited to, Hypertension (elevated blood pressure), Quadriplegia (weakness or paralysis of all 4 limbs), and Traumatic Brain Injury. Resident #87's most recent Minimum Data Set (MDS) Assessment was an Entry Tracking Assessment with an Assessment Reference Date (ARD) of 10/26/2018. Resident #87 was coded as rarely or never understood. The Staff Assessment for Mental Status coded Resident #87 as three - Severely Impaired.

On 11/14/2018, a review of Resident #87's record was conducted. It was noted that Resident #87 was discharged to the hospital on 10/20/2018. Upon examination of the medical record, no documentation could be located evidencing that the facility had provided Resident #87 or their Responsible Party (RP) with a copy of the facility Bed Hold policy at the time of discharge.

On 11/15/2018 at 4:09p.m., an interview was conducted with Other Staff Member (OSM) #4, the Admissions Director. She was asked about the process for making bed holds when a resident is admitted to the hospital. OSM #4 stated that when a resident is sent to the hospital, the facility waits to see if the resident is admitted.

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If admitted, then the following morning the facility calls the responsible party (RP) to explain the Bed Hold. If the family/RP elects to pay for a Bed Hold, they have to fill out a form and pay the fee. OSM #4 stated that she does not usually document the fact that the call is made, she usually only documents if the RP elects to make a Bed Hold. OSM #4 stated the Bed Hold agreement is only provided at the time of admission to the facility, or if the RP elects to pay for a Bed Hold during a hospital stay.

The Administrator, (ASM [administrative staff member] #1) and ASM #2, the Director of Nursing were informed of the findings at the end of day meeting on 11/16/2018. No further information was provided.

4. The facility staff failed to provide Resident # 49 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/23/18.

Resident # 49 was admitted to the facility on 11/21/17 and a readmission on 09/26/18 with diagnoses that included but were not limited to osteoarthritis (1), hemiplegia (2), anxiety (3) and chronic obstructive pulmonary disease (4).

Resident # 49's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/28/18, coded Resident # 49 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 49 dated 09/23/2018 documented, "14:53 (2:53 p.m.) Patient complained chest pain that radiated

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to her back. Pain in both arms and legs. BP (blood pressure) 177/78 (177 over 78). She complained of SOB (shortness of breath). Lungs sounds clear in all quadrants, O2 (oxygen) 98% (percent). MD (medical doctor) (Name of Doctor) order she be sent out. Patient transported to (Name of Hospital)."

Review of the EHR (electronic health record) for Resident # 49 failed to evidence that Resident # 49 or the resident's representative was provided a written notification of the bed hold policy when the resident was transferred to the hospital on 09/23/18.

On 11/15/18 at approximately 4:09 p.m., an interview was conducted with OSM (other staff member) # 4, the admission director. When asked to describe the procedure for offering the written bed hold policy when a resident has a facility initiated transfer to a hospital, OSM # 4 stated, "We usually don't. When the resident is admitted, we call the family in the morning and offer the bed hold, and let them know if they want to keep the same bed they need to fill out the form and pay the fee. We sometimes document that we talk to them, usually if they agree to bed hold we give it to them. We have a written notification of the bed hold when they sign the written agreement at the time of admission." When asked if written bed hold information is provided to the resident and or responsible party at the time of transfer to the hospital, OSM #4 stated, "Only if the resident wants to keep the same bed."

On 11/16/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing,

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ASM # 3 regional consultant, ASM # 4 regional consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.

(2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

5. The facility staff failed to provide Resident # 46 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 07/20/18.

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Resident # 46 was admitted to the facility on 03/03/17 and a readmission on 10/15/18 with diagnoses that included but were not limited to rheumatoid arthritis (1), dysphagia (2), anxiety (3) and hypertension (4).

Resident # 46's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/18, coded Resident # 46 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 46 dated 07/20/2018 documented, "Change of Condition. 17:51 (5:51 p.m.) Resident's lab (laboratory) results sent to (Name of Doctor) and he ordered that the resident be sent to ER (emergency room). Resident was informed and refused at first. Called unit manager then DON (director of nursing) and myself and another nurse went back to the room and asked resident again about going to ER and this time she agreed to go -911 has been called, made call to (Name of Responsible Party) message left on home phone, cell phone can not (Sic.) accept message, mailbox is full."

Review of the EHR (electronic health record) for Resident # 46 failed to evidence that Resident # 49 or the resident's representative was provided a written notification of the bed hold policy when the resident was transferred to the hospital on 07/20/18.

On 11/15/18 at approximately 4:09 p.m., an interview was conducted with OSM (other staff member) # 4, the admission director. When

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asked to describe the procedure for offering the written bed hold policy when a resident has a facility initiated transfer to a hospital, OSM # 4 stated, "We usually don't. When the resident is admitted, we call the family in the morning and offer the bed hold, and let them know if they want to keep the same bed they need to fill out the form and pay the fee. We sometimes document that we talk to them, usually if they agree to bed hold we give it to them. We have a written notification of the bed hold when they sign the written agreement at the time of admission." When asked if written bed hold information is provided to the resident and or responsible party at the time of transfer to the hospital, OSM #4 stated, "Only if the resident wants to keep the same bed."

On 11/16/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3 regional consultant, ASM # 4 regional consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) Fear. This information was obtained from the

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F 625	Continued From page 38 website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		12/18/18

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F 656	Continued From page 39 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, facility document review, and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for one of 38 residents in the survey sample, Resident #32. The facility staff failed to develop and implement an activities care plan to address and include Resident #32's activity preference for the use music. The findings include: Resident #32 was admitted to the facility on 1/6/12 with diagnoses that included but were not limited to: multiple sclerosis [a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover. (1)], diabetes, high blood pressure, depression, contractures, and has a gastrostomy tube. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 656	F-656 1. Resident #32□s Care plan has since been updated with Music Therapy to include: Spiritual/gospel; Oldies; and Motown favorites. 2. All Residents are at risk. 3. SDC or designee to educate Activities department on updating care plans with the residents□ current preferences for activities. 4. DON or Designee will audit 100% of residents□ activity care plans for updated activity preference, then 20% of resident care plans 5x weekly for 4 weeks, then review the findings in following QA meeting. 5. Date of Compliance- 12.18.2018.	

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assessment reference date of 9/13/18, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #32 was coded as being completely dependent upon one or more staff members for all of his activities of daily living.

An interview was conducted with Resident #32's aunt, who visits almost daily, on 11/14/18 at approximately 2:00 p.m. When asked what type of activities the resident receives, Resident #32's aunt stated that she is concerned with his activity participation. She stated when she is here; she wheels him around the facility. His only activity is watching/listening to the television. She stated that he likes music.

The comprehensive care plan dated, 3/6/14 and revised on 9/10/18, documented in part, "Focus: The resident is dependent on staff for meeting emotional, intellectual, physical and social needs r/t (related/to) physical limitations, immobility, cognitive deficits." The "Interventions" documented in part, "Encourage ongoing family involvement. Invite the resident's family to attend special events, activities. Continue to inquire activity preference of resident from the family (family say patients' past activity preference was music)."

Observations were made throughout the survey process. Resident #32 was observed on 11/14/18 to remain in his bed with the television on. His aunt stayed at his bedside until approximately 4:00 p.m. On 11/15/18, Resident #32 was observed up in his wheelchair, by the side of his bed. The television was on. His aunt did not visit this day. He was never observed out of his room.

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There was no device in the resident's room to play music.

The "Activities Reassessment" dated, 6/13/18, documented in part, "C. Attendance and Participation Summary" documented in part, "Resident is dependent on staff for emotional, intellectual, physical and social needs r/t (related to) phys (physical) limitations, immobility, cognitive deficits. Family in daily suppling (sic). He show enjoyment through facility expression during visits. TV is on in room throughout the day. Staff visit/clergy visit." The form further documented, "Limitation/Special Needs" documented, "Resident enjoys music/facial expressions."

An interview was conducted with other staff member (OSM) #1, the director of activities, on 11/15/18 at 3:39 p.m. When asked which activities are provided to Resident #32, OSM #1 stated, "We provide one to one, and he gets a lot of time with his family." When asked what activities she and her staff provide, OSM #1 stated, "We talk to him. He used to like the Redskins, so we talk about that." When asked how long her staff spends with Resident #32, OSM #1 stated, "About 10 -15 minutes two to three times per week." When asked if music stimulation is provided to Resident #32, OSM #1 stated, "I haven't on my one to one time." When asked what type of music Resident #32 likes, OSM #1 stated she did not know. OSM #1 was asked to provide documentation of the activities provided to Resident #32.

The "Independent Activity" documentation for the month of October 2018 and the month of November 2018 was provided by OSM #1, the

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director of activities on 11/15/18 at 3:54 p.m. During the month of October, the resident had 44 opportunities for documentation of activities provided. Of those 44 opportunities, 26 were documented as, "Volunteer/Guest visits." The other 18 were documented as, "Television/Movies/Entertainment." There was no documentation of any music therapy provided. During the month of November 2018, there were 20 opportunities for documentation of activities provided. Of those 20, 12 were documented as "Volunteer/Guest visits." The other eight were documented as "Television/Movies/Entertainment." There was no documentation of music being provided. OSM #1 stated, "I guess it's our fault." When asked if it is the responsibility of Resident #32's aunt to provide activities for him, OSM #1 stated, "No, it's both of ours."

On 11/16/18 at 10:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe the purpose of the care plan, LPN # 3 stated, "It tell how to care for the resident and what their needs are." When asked why it was important to follow the resident's care plan, LPN # 3 stated, "If someone does not know the resident the care plan is a guide as to how to care for the resident so you can give the proper care."

The facility policy, "Resident Assessment and Care Planning" documented in part, " POLICY: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-entered care, and the necessary health-related care and services to attain or maintain the highest

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F 656	Continued From page 43 practicable physical, mental and psychosocial well-being of the patient...4. The comprehensive assessment and plan of care will include, at a minimum, input obtained from the attending physician, the nurse and the nurse assistant who has responsibility for the patient; a member of the food and nutrition services staff, other appropriate staff or professionals as needed or requested by the patient and to the extent practicable, the participation of the patient and the patient's representative. If it is determined not practicable for the patient and/or representative to participate, a progress note must be entered with explanation into the medical record. ..6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		12/18/18

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F 657	Continued From page 44 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, resident interview, and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of 38 residents in the survey sample, Resident #23. The facility staff failed to review and revise the comprehensive care plan when Resident #23's days for dialysis were changed. The findings include: Resident #23 was admitted to the facility on 6/20/16 with diagnoses, which included but were not limited to: end stage renal disease [The last stage of chronic kidney disease. This is when	F 657	F-657 1. Resident #23□s care plan has since been updated with current dialysis schedule. 2. Residents receiving dialysis are at risk. 3. SDC or designee to educate licensed nursing staff on maintaining a current and accurate care plan inclusive of the current ordered dialysis days. 4. DON or designee will audit 100% of residents receiving dialysis for current care plan inclusive of the current ordered dialysis days weekly for 4 weeks, then review findings in following QA meeting. 5. Date of Compliance- 12.18.2018.	

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your kidneys can no longer support your body's needs. (1)] requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine. (2)], high blood pressure, low back pain, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/18 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as receiving dialysis while a resident at the facility.

The comprehensive care plan dated, 6/21/16 and revised on 10/6/18, documented in part, "Focus: Hemo-Dialysis: The resident needs hemodialysis r/t (related to) end stage renal failure. (Name and phone number of dialysis center). Dialysis shunt site to L (left) bicep, resident has history of refusing dialysis." The "Interventions" documented in part, "Hemodialysis on Tuesday, Thursday and Saturdays."

The physician orders dated, 5/1/17, documented as an "active order," documented, "Dialysis Tue (Tuesday) Thur (Thursday) and Sat (Saturday) at (name of dialysis center and phone number of center)."

An interview was conducted with Resident #23 on 11/15/18 at 1:34 p.m. When asked what days he goes to dialysis, Resident #23 stated he is on a Monday - Wednesday - Friday schedule for 25 years. He was switched to a Tuesday - Thursday

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- Saturday schedule. However, has gone back to the Monday - Wednesday - Saturday schedule. When asked when he went back on the Monday - Wednesday - Friday schedule, Resident #23 stated he's been on it for two to three months."

An interview was conducted with LPN (licensed practical nurse) #1, the nurse caring for Resident #23, on 11/15/18 at 2:06 p.m. When asked what days Resident #23 goes to dialysis, LPN #1 stated, "I believe it is Monday - Wednesday and Fridays." The 5/1/17, physician order for dialysis was reviewed with LPN #1. LPN #1 stated, "He goes Monday - Wednesday - Fridays." When asked if the physician order should have been updated, LPN #1 stated, "Yes, Ma'am." When asked if the comprehensive care plan should be updated with the current days the resident goes to dialysis, LPN #1 stated, "Yes, Ma'am."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, and ASM #3, the regional consultant, on 11/15/18 at 2:22 p.m. When asked about the process followed for a resident going to dialysis, ASM #2 stated, "There needs to be a physician order that states the days they go and the location of the dialysis center." When asked if dialysis should be addressed on the comprehensive care plan, ASM #2 stated, "The care plan should equal the physician order for dialysis days."

The facility policy, "Resident Assessment and Care Planning" documented in part, "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment."

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F 657	Continued From page 47 According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m. When asked which professional standard of practice the facility follows, ASM #3 stated the facility uses Lippincott. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000500.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		12/18/18

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F 658	Continued From page 48 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 38 residents in the survey sample, Residents # 49 and # 23. 1. The facility staff failed to clarify physician's orders for two as needed pain medications, Tramadol (1) and Tylenol (2) to determine which, as needed pain medication should be administered to Resident #49 based on pain level parameters. 2. The facility staff failed to clarify a physician order for the days Resident #23 went to dialysis. The findings include: 1. The facility staff failed to clarify physician's orders for two as needed pain medications, Tramadol (1) and Tylenol (2) to determine which, as needed pain medication should be administered to Resident #49 based on pain level parameters. Resident # 49 was admitted to the facility on 11/21/17 and a readmission on 09/26/18 with diagnoses that included but were not limited to osteoarthritis (3), hemiplegia (4), anxiety (5) and chronic obstructive pulmonary disease (6). Resident # 49's most recent MDS (minimum data	F 658	F-658 1. Resident #49□s orders for Tramadol and Tylenol have since been clarified to reflect pain scale parameters. Resident 23□s Dialysis orders have since been clarified to reflect the current schedule. 2. All residents receiving pain medication and/or dialysis are at risk. 3. SDC or designee to educate licensed nursing staff on: a. Ensuring resident receiving multiple pain medications or different pain medication doses based on severity of pain have parameters in place to ensure appropriate pain management. b. Ensuring residents receiving dialysis have current orders that reflect the appropriate days of residents current dialysis schedule. 4. DON or designee will audit: a. 100% of residents receiving multiple pain medications or different pain medication doses based on severity of pain for parameters in place, then 20% of patients weekly for 2 weeks, then 10% weekly for 2 weeks, then review findings in following QA meeting. b. 100% of residents receiving dialysis for current orders that reflect the appropriate days of the current dialysis schedule weekly for 4 weeks, then review findings in following QA meeting.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 49 set), a quarterly assessment with an ARD (assessment reference date) of 09/28/18, coded Resident # 49 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 49 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. The POS (physician's order sheet) for Resident # 49 dated "November 2018 documented, "Tramadol Tablet 50 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Created Date: 03/19/2018. Revision Date: 10/27/2018." "Tylenol Tablet 325 MG. Give 1 (one) tablet by mouth every 4 (four) hours as needed for pain. Created Date: 03/16/2018. Revision Date: 10/20/2018." Review of the eMAR (electronic medication administration record) for Resident # 49 dated October 2018 documented the above physician's orders. Further review of the eMAR dated October 2018, revealed Tramadol 50 MG was administered to Resident # 49 on: - 10/10/18 at 4:02 p.m., with a pain level of four. - 10/16/18 at 12:02 a.m. with a pain level of nine, - 10/20/18 at 5:35 a.m. with a pain level of ten, - 10/23/18 at 3:59 a.m. with a pain level of nine, - 10/24/18 at 6:29 with a pain level of eight, - 10/26/18 at 4:40 a.m. with a pain level of eight and at 10:28 p.m. with a pain level of five, - 10/27/18 at 7:55 a.m. with a pain level of four and on 10/28/18 at 9:17 p.m. with a pain level of six. Further review of the eMAR revealed Tylenol 325 MG was administered to Resident # 49 on 10/08/18 at 6:38 a.m. with a pain level of four.	F 658	6. Date of Compliance- 12.18.2018.	

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F 658	Continued From page 50 On 11/16/18 at 10:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe the procedure for the administration of PRN (as needed) pain medication, LPN # 3 stated, "Ask the resident where the pain is, using a scale of one to ten, ask what is the pain level is, try to alleviate the resident's pain by other means before giving the pain medication. If the intervention does not work then I offer the pain med [medication]." When asked to describe the procedure for determining the pain medication to be administered when there is a physician's order for two as needed pain medications, LPN # 3 stated, "I would go by the resident's description of the pain intensity, if a mild pain like a headache, I would give Tylenol, if excruciating pain I would give something stronger." LPN # 3 was asked how a nurse would know which as needed pain medication should be administered after reviewing the October 2018 eMAR for Resident # 49. LPN # 3 stated, "The order should be clarified." When asked why it was important to clarify the physician's as needed pain medication orders, LPN # 3 stated, "So we have guidelines from the physician as to which pain medication to administer for the levels of mild moderate and severer pain." On 11/16/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3 regional consultant, ASM # 4 regional consultant, were made aware of the findings. When asked which professional standard of practice the facility follows, ASM #3 stated the facility uses Lippincott.	F 658		

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F 658	Continued From page 51 According to Lippincott's "Fundamentals of Nursing, 5th edition, page 553 documents the following statement, "Always clarify with the prescriber any medication order that is unclear or seems in appropriate." No further information was provided prior to exit. References: (1) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. (2) Acetaminophen (Tylenol) is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.	F 658		

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(3) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.

(4) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(6) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.
2. The facility staff failed to clarify a physician order for the days Resident #23 went to dialysis.

Resident #23 was admitted to the facility 0n 6/20/16 with diagnoses, which included but were not limited to: end stage renal disease [The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. (1)] requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine. (2)], high blood

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pressure, low back pain, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/18 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as receiving dialysis while a resident at the facility.

The comprehensive care plan dated, 6/21/16 and revised on 10/6/18, documented in part, "Focus: Hemo-Dialysis: The resident needs hemodialysis r/t (related to) end stage renal failure. (Name and phone number of dialysis center). Dialysis shunt site to L (left) bicep, resident has history of refusing dialysis." The "Interventions" documented in part, "Hemodialysis on Tuesday, Thursday and Saturdays."

The physician orders dated, 5/1/17, documented as an "active order," documented, "Dialysis Tue (Tuesday) Thur (Thursday) and Sat (Saturday) at (name of dialysis center and phone number of center)."

An interview was conducted with Resident #23 on 11/15/18 at 1:34 p.m. When asked what days he goes to dialysis, Resident #23 stated he is on a Monday - Wednesday - Friday schedule for 25 years. He was switched to a Tuesday - Thursday - Saturday schedule. However, has gone back to the Monday - Wednesday - Saturday schedule. When asked when he went back on the Monday - Wednesday - Friday schedule, Resident #23 stated he's been on it for two to three months."

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The comprehensive care plan dated, 6/21/16 and revised on 10/6/18, documented in part, "Focus: Hemo-Dialysis: The resident needs hemodialysis r/t (related to) end stage renal failure. (Name and phone number of dialysis center). Dialysis shunt site to L (left) bicep, resident has history of refusing dialysis." The "Interventions" documented in part, "Hemodialysis on Tuesday, Thursday and Saturdays."

An interview was conducted with LPN (licensed practical nurse) #1, the nurse caring for Resident #23, on 11/15/18 at 2:06 p.m. When asked what days Resident #23 goes to dialysis, LPN #1 stated, "I believe it is Monday - Wednesday and Fridays." The 5/1/17, physician order for dialysis was reviewed with LPN #1. LPN #1 stated, "He goes Monday - Wednesday - Fridays." When asked if the physician order should have been updated, LPN #1 stated, "Yes, Ma'am." When asked if the comprehensive care plan should be updated with the current days the resident goes to dialysis, LPN #1 stated, "Yes, Ma'am."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, and ASM #3, the regional consultant, on 11/15/18 at 2:22 p.m. When asked about the process followed for a resident going to dialysis, ASM #2 stated, "There needs to be a physician order that states the days they go and the location of the dialysis center."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m.

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F 658	Continued From page 55 ASM #3 informed this surveyor the facility did not have a policy on clarifying physician orders. When asked which professional standard of practice the facility follows, ASM #3 stated the facility uses Lippincott. According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, and obtain appropriate orders. c. Notify all involved medical and nursing personnel.... d. Document clearly." No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000500.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility	F 677	F-677	12/18/18

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F 677	Continued From page 56 staff failed to ensure the necessary care and services to maintain good personal hygiene were provided in a timely manner for one of 38 residents in the survey sample, Residents # 14. The facility staff failed to ensure Resident #14 was provided incontinence care in a timely manner. The findings include: Resident # 14 was admitted to the facility on 11/17/14 with diagnoses that included but were not limited to legal blindness, gastroesophageal reflux disease (1), dysphagia (2), depressive disorder (3) and hypertension (4). Resident # 14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/23/18, coded Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 14 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. Section H "Bladder and Bowel" coded Resident # 14 as being "Always incontinent of urine and bowel." The comprehensive care plan for Resident # 14 dated 12/02/2014 and a revision date of 09/04/2018 documented in part, "Focus: The resident has an ADL (activity of daily living) self-care performance deficit r/t (related to) Limited Mobility, Confusion. Participation in her ADLs varies depending on how she is feeling.. She is incontinent of bowel and bladder." Under "Interventions" it documented in part,	F 677	1. Resident #14 has since been provide necessary incontinence care without delay. 2. All residents dependent on staff for incontinence care are at risk. 3. SDC or designee will educate nursing staff providing incontinence care on the importance of providing immediate care when notified of resident□s need for brief change. 4. DON or designee will audit 20% of resident□s dependent on staff for incontinence for timeliness of brief changes daily for 1 week, then 20% 5x weekly for 2 weeks, then 10% 5x weekly for 1 week, then review findings in following QA meeting. 5. Date of Compliance: 12.18.2018.	

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"PERSONAL HYGIENE/ORAL CARE: The resident requires assistance to perform personal hygiene and oral care. TOILET USE: The resident refuses to go to the toilet or use bedpan. Requires assistance with incontinence care. Bowel and bladder program was offered but declined."

On 11/15/18 08:57 a.m., during an interview with Resident # 14, she stated that she had urinated in her brief at approximately 8:00 a.m. and rang the call bell and "no one has come to take care of me yet. I told the housekeeper I needed to be changed and she said she would try and find someone that was just before you came in here."

On 11/15/18 at 9:14 a.m., an observation of Resident # 14's room revealed CNA (certified nursing assistant) # 1 entering Resident # 14's room, providing the resident with her breakfast tray and setting her up to eat. Resident # 14 was over-heard telling CNA # 1 that she was wet. CNA # 1 told Resident # 1 she would go to find (Name of CNA # 2).

On 11/15/18 at 9:33 a.m., an observation of Resident # 14's room revealed CNA # 1 entering the resident's room speaking with Resident # 14. Resident # 14 was over-heard stating, "I need my brief changed." CNA # 1 stated, "I can do it after you eat."

11/15/18 09:46 a.m., an observation of Resident # 14's room revealed CNA # 2 entering Resident # 14's room and asking Resident # 14 if she was finished with her breakfast. Resident # 14 was over-heard stating yes. CNA # 2 removed the breakfast tray and stated she would be right back. This surveyor then entered Resident # 14's room

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and interviewed the resident about her incontinence care. Resident # 14 stated she told CNA # 2 she needed to be changed.

On 11/15/18 at 9:48 a.m., an observation of Resident # 14's room revealed CNA # 2 entered Resident # 14's room, closed the door and provided incontinence care.

On 11/15/18 at 9:57 a.m., an observation of Resident # 14's room revealed CNA # 2 emerged from Resident # 14's room with a bag containing a soiled brief.

On 11/15/18 at 9:03 a.m., an interview was conducted with OSM (other staff member) # 6, housekeeper. When asked if she visited Resident # 14 earlier that morning, OSM # 6 stated, "Yes. I saw the light on she told me she was waiting for (CNA # 2) to come in change her. The nurse also knew she need to be changed and saw the light and came in and cut if off and stated that (CNA # 2) would be right in." When asked what time this occurred OSM # 6 stated, "At about 8:25 (a.m.)."

On 11/15/18 at 9:58 a.m., an interview was conducted with CNA # 2. When asked about Resident # 14's incontinence care, CNA # 2 stated, "I changed (Resident # 14's) brief. When asked if the brief was soiled, CNA # 2 stated, "Yes with urine." When asked when she knew Resident # 14 required incontinence care, CNA # 2 stated, "The first I knew she needed to be changed was when I went in to get her tray." When asked to describe the procedure for incontinence care, CNA # 2 stated, "The resident should be changed immediately after we know about it." When asked if a resident should have

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to wait for incontinence care, CNA # 2 stated, "No."

On 11/15/18 at 10:06 a.m., an interview was conducted with LPN (licensed practical nurse) # 3, charge nurse. When asked if she recalled answering the call light or knew that (Resident # 14) was wet LPN # 3 stated, "No."

On 11/15/18 at 10:17 a.m., an interview was conducted with CNA # 1. When asked if Resident # 14 spoke to her when she took the breakfast tray into Resident # 14's room, CNA # 1 stated, "She asked who her aid was I told her (CNA # 2). She stated she needed to see her. She told me she was soiled. I told the resident (Resident # 14) I would change her after breakfast. We wouldn't stop breakfast and change the resident."

On 11/15/18 at 10:22 a.m., LPN # 3 came up to this surveyor and stated, "I spoke with (OSM # 6) and to make sure what transpired. So I was in Resident # 14's room, turned off the call light. Resident # 14 did say she needed to be changed. When I went to (Resident # 14's) door, staff were calling me because another resident fell on my hall and because of that, I forgot about Resident # 14 needing to changed. Someone should have taken care of Resident # 14. I should have sent someone to take care of Resident # 14 when I went to take care of the fall." When asked why it was important to provide timely incontinence care, LPN # 3 stated, "Skin could break down." When asked to describe the procedure for incontinence care, LPN # 3 stated, "Incontinence care should be done immediately when staff are notified."

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BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 60 On 11/16/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3 regional consultant, ASM # 4 regional consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		12/18/18

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F 679	Continued From page 61 the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, facility document review, and clinical record review, it was determined the facility staff failed to provide an activity program to meet the resident's needs, per the resident's preferences for one of 38 residents in the survey sample, Resident #32. The facility staff failed to offer and provide Resident #32 with music activities, which was identified by the resident's family on the comprehensive care plan as being a preferred activity for Resident #32. The findings include: Resident #32 was admitted to the facility on 1/6/12 with diagnoses that included but were not limited to: multiple sclerosis [a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover. (1)], diabetes, high blood pressure, depression, contractures, and has a gastrostomy tube. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the resident as having both short and long-term memory difficulties. The resident was coded as	F 679	F-679 1. Resident #32 is now being provided with music per resident preference including spiritual/gospel and Motown/oldies. 2. All residents are at risk. 3. The SDC or designee will educate the activities staff and all nursing staff on providing resident with preferred music choices on one to one visits and per request of family. 4. DON or designee will audit 50% of residents for participation and one to one visits; for preferred activities being provided x2 weeks, then 25% for 2 weeks, then review findings in following QA meeting. 5. Date of Compliance: 12.18.2018.	

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F 679	Continued From page 62	F 679		

being severely impaired to make daily cognitive decisions. Resident #32 was coded as being completely dependent upon one or more staff members for all of his activities of daily living.

An interview was conducted with Resident #32's aunt, who visits almost daily, on 11/14/18 at approximately 2:00 p.m. When asked what type of activities the resident receives, Resident #32's aunt stated that she is concerned with his activity participation. She stated when she is here; she wheels him around the facility. His only activity is watching/listening to the television. She stated that he likes music.

Observations were made throughout the survey process. Resident #32 was observed on 11/14/18 to remain in his bed with the television on. His aunt stayed at his bedside until approximately 4:00 p.m. On 11/15/18, Resident #32 was observed up in his wheelchair, by the side of his bed. The television was on. His aunt did not visit this day. He was never observed out of his room. There was no device in the resident's room to play music.

The "Activities Reassessment" dated, 6/13/18, documented in part, "C. Attendance and Participation Summary" documented in part, "Resident is dependent on staff for emotional, intellectual, physical and social needs r/t (related to) phys (physical) limitations, immobility, cognitive deficits. Family in daily suppling (sic). He show enjoyment through facility expression during visits. TV is on in room throughout the day. Staff visit/clergy visit." The form further documented, "Limitation/Special Needs" documented, "Resident enjoys music/facial expressions."

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F 679	Continued From page 63	F 679		

The comprehensive care plan dated, 3/6/14 and revised on 9/10/18, documented in part, "Focus: The resident is dependent on staff for meeting emotional, intellectual, physical and social needs r/t (related/to) physical limitations, immobility, cognitive deficits." The "Interventions" documented in part, "Encourage ongoing family involvement. Invite the resident's family to attend special events, activities. Continue to inquire activity preference of resident from the family (family say patients' past activity preference was music)."

An interview was conducted with other staff member (OSM) #1, the director of activities, on 11/15/18 at 3:39 p.m. When asked which activities are provided to Resident #32, OSM #1 stated, "We provide one to one, and he gets a lot of time with his family." When asked what activities she and her staff provide, OSM #1 stated, "We talk to him. He used to like the Redskins, so we talk about that." When asked how long her staff spends with him, OSM #1 stated, "About 10 -15 minutes two to three times per week." When asked if she provided music stimulation, OSM #1 stated, "I haven't on my one to one time." When asked what type of music Resident #32 likes, OSM #1 stated she did not know. OSM #1 was asked to provide documentation of the activities provided to Resident #32.

The "Independent Activity" documentation for the month of October 2018 and the month of November 2018 was provided by OSM #1, the director of activities on 11/15/18 at 3:54 p.m. During the month of October, the resident had 44 opportunities for documentation of activities

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provided. Of those 44 opportunities, 26 were documented as, "Volunteer/Guest visits." The other 18 were documented as, "Television/Movies/Entertainment." There was no documentation of any music therapy provided. During the month of November 2018, there were 20 opportunities for documentation of activities provided. Of those 20, 12 were documented as "Volunteer/Guest visits." The other eight were documented as "Television/Movies/Entertainment." There was no documentation of music being provided. OSM #1 stated, "I guess it's our fault." When asked if it is the responsibility of Resident #32's aunt to provide activities for him, OSM #1 stated, "No, it's both of ours."

The facility policy, "Program Management" documented in part, "POLICY: The activities department will provide, based on the comprehensive assessment and care plan and the preferences of each patient, an ongoing program to support patients in their choice of activities, both facility sponsored group, individual activities, and independent activities designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident, encouraging both independence and interaction in the community...These may include facility sponsored groups, individual activities, and independent activities that: are related to patient's previous work, life roles, like-long interests, culture, spiritual preference."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m.

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F 679	Continued From page 65 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380	F 679		
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: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence communication with the dialysis center for one of 38 residents in the survey sample, Resident #23. The facility staff failed to evidence that an ongoing communication system was in place with the dialysis center for Resident #23. The findings include: Resident #23 was admitted to the facility 0n 6/20/16 with diagnoses, which included but were not limited to: end stage renal disease [The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. (1)] requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine. (2)], high blood pressure, low back pain, and muscle weakness.	F 698	F-698 1. Resident #23 now has dialysis communication book in place. 2. All residents receiving dialysis are at risk. 3. SDC or designee to educate all licensed nurses on ensuring that the dialysis books are sent with any resident on days dialysis is designated. 4. Administrator or designee will audit 100% of residents on dialysis for transfer and return of dialysis communication book on residents dialysis days 6x weekly for 4 weeks, then review findings in following QA meeting. 5. Date of Compliance: 12.18.2018.	12/18/18

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/18 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as receiving dialysis while a resident at the facility.

The physician orders dated, 5/1/17, documented as an "active order," documented, "Dialysis Tue (Tuesday) Thur (Thursday) and Sat (Saturday) at (name of dialysis center and phone number of center)."

The review of the clinical record, failed to evidence documentation of any communication with the dialysis center.

An interview was conducted with LPN (licensed practical nurse) #1 on 11/15/18 at 2:06 p.m. When asked what information goes with a resident to dialysis, LPN #1 stated, "A face sheet, and the communication book. Most of the time the book spends most of the time in their bags on their wheelchair." When asked if she knew where Resident #23's communication book was located, LPN #1 looked in the nurse's station and then asked if she could go find the proper answer. LPN #1 went to Resident #23's room. LPN #1 asked the resident where his communication book was, Resident #23 stated, he didn't have a communication book. When asked why it is important to have communication with the dialysis center, LPN #1 stated, "We send any changes in their condition, any new orders or laboratory test

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F 698	Continued From page 67	F 698		

results with them. They (the dialysis center) sends back how much fluid they take off, the weights before and after dialysis. The dialysis center will call with new orders and then faxes them to us. He goes Monday, Wednesday and Fridays so there should be communication each time he goes."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 11/15/18 at 2:22 p.m. When asked how the facility communicates with the dialysis center that one of their residents goes to, ASM #2 stated, "We communicate with them by telephone." When asked if they send anything with them, ASM #2 stated, "We used to, if there are any changes to the orders they call us or fax us. We have a book that is supposed to go with them." ASM #2 was asked to provide any evidence of documentation of communication with the dialysis center for Resident #23.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000500.htm.

(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.

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F 761	Continued From page 68	F 761		
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 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store medications in accordance with professional standards in two of five medications carts, carts one and three on the B unit. 1. The facility staff failed to store insulin according to manufacturer's instructions on the unit B	F 761	F-761 1. All medications carts have been checked and cleared of any inappropriately stored and/or expired medications. 2. All residents are at risk. 3. SDC or designee to educate licensed nursing staff on ensuring that all	12/18/18

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F 761	Continued From page 69 medication cart one. 2. The facility staff failed to store insulin according to manufacturer's instructions on the unit B medication cart three. The findings include: 1. The facility staff failed to store insulin (1) according to manufacturer's instructions on the unit B medication cart one. On 11/15/18 at 1:55 p.m., observation of the unit B medication cart one was conducted with LPN (licensed practical nurse) #4. The following was observed: - One open Humulin 70/30 kwikpen (2) with no labeled open date. The label on the pen documented the pen was dispensed from the pharmacy on 10/5/18. A sticker on the pen documented to discard the pen 10 days after opened. LPN #4 was asked the facility process for labeling insulin once opened. LPN #4 stated the pens should be labeled with the open date once the pens are taken out of the refrigerator and opened. When asked why, LPN #4 stated, "Because some insulins are only good for like 14 days, 21 days or 30 days. It helps us determine the expiration dates once opened." LPN #4 stated she was unaware when the pen was opened. The manufacturer's instructions documented, "Throw away the HUMULIN 70/30 Pen you are using after 10 days, even if it still has insulin left in it." - One unopened Levemir flextouch pen (3). A sticker on the pen documented to refrigerate the pen until opened. LPN #4 confirmed the pen was unopened and should have been in the	F 761	medications are not expired and are stored appropriately per manufacturers guidelines. 4. DON or designee will audit 100% medication carts for inappropriately stored and/or expired medications for 3 times weekly for 2 weeks, then weekly for two weeks, then review findings in following QA meeting. 5. Date of Compliance- 12.18.2018.	

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F 761	Continued From page 70	F 761		

refrigerator. The manufacturer's instructions documented, "Unopened Levemir® should be kept in the refrigerator at a temperature range between 36° and 46°F (2° and 8°C)."

-One Humalog kwikpen (4) with a sticker that documented the pen was opened on "8-31." Another sticker on the pen documented to discard the pen 28 days from opening. LPN #4 confirmed the pen should not have been in the medication cart and should have been discarded. The manufacturer's instructions documented, "You will need to discard your Humalog KwikPen after 28 days in use, even if insulin remains."

On 11/15/18 at 5:39 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility pharmacy policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "4. Facility should ensure that medications and biologicals: 4.1 Have an Expiration Date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened... 11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges..."

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No further information was presented prior to exit.

(1) Insulin is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/diabetestype1.html

(2) Humulin 70/30 kwikpen is insulin used to treat diabetes. This information was obtained from the website: http://pi.lilly.com/us/HUMULIN-7030-KWIKPEN-IFU.pdf

(3) Levemir flextouch pen is insulin used to treat diabetes. This information was obtained from the website: https://www.levemir.com/about-levemir.html

(4) Humalog kwikpen is insulin used to treat diabetes. This information was obtained from the website: https://www.humalog.com/type-2-diabetes/

2. The facility staff failed to store insulin (1) according to manufacturer's instructions on the unit B medication cart three.

On 11/15/18 at 2:11 p.m., observation of the unit B medication cart three was conducted with LPN (licensed practical nurse) #5. One unopened Humalog kwikpen (2) was observed in the medication cart. A sticker on the pen documented to refrigerate the pen until opened. LPN #5 confirmed the pen was unopened and should have been in the refrigerator. When asked why, LPN #5 stated, "It keeps the preservation (of the medication)." The manufacturer's instructions documented, "Unopened Humalog should be stored in a

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F 761	Continued From page 72 refrigerator..." On 11/15/18 at 5:39 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) Insulin is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/diabetestype1.html (2) Humalog kwikpen is insulin used to treat diabetes. This information was obtained from the website: https://www.humalog.com/type-2-diabetes/	F 761		
F 842 SS=D	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 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;	F 842		12/18/18

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	495297	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

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F 842	Continued From page 73 (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. §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	F 842		

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F 842	Continued From page 74 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 resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 38 residents in the survey sample, Resident #23. The facility staff documented the application of a dialysis pressure dressing treatment to Resident #23 on the residents TAR (treatment administration record) for dates when the resident did not receive dialysis. The findings include: Resident #23 was admitted to the facility 0n 6/20/16 with diagnoses, which included but were not limited to: end stage renal disease [The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. (1)] requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine. (2)], high blood pressure, low back pain, and muscle weakness. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/18 coded the	F 842	F-842 1. Resident #23□s MD has since been made aware of the documentation error, and the order changed to reflect the appropriate dialysis days to check pressure dressing. 2. All Residents receiving dialysis are at risk. 3. SDC or designee to educate licensed nursing staff on ensuring that orders are updated with any change in dialysis days so dialysis site management is accurate in the clinical record. 4. DON or Designee will audit 100% of residents receiving dialysis for appropriate site management orders to ensure they are reflective of the dialysis days, then 100% weekly for 4 weeks, then review findings in following QA meeting. 5. Date of Compliance- 12.18.2018.	

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F 842	Continued From page 75	F 842		

resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as receiving dialysis while a resident at the facility.

The physician's order dated, 7/3/17, documented, "Dialysis pressure dressing in place 24 hrs (hours) after dialysis every shift every Tue (Tuesday), Thu (Thursday) Sat (Saturday) related to end stage renal disease."

The TAR (treatment administration record) for the month of November 2018 documented the above physicians order. The nurses signed off the dressing was in place on the following days and times:
11/1/18 - Thursday - all three shifts
11/3/18 - Saturday - all three shifts
11/6/18 - Tuesday - all three shifts
11/8/18 - Thursday - all three shifts
11/10/18 - Saturday - all three shifts
11/13/18 - Tuesday - all three shifts

The physician orders dated, 5/1/17, documented as an "active order," documented, "Dialysis Tue (Tuesday) Thur (Thursday) and Sat (Saturday) at (name of dialysis center and phone number of center)."

An interview was conducted with Resident #23 on 11/15/18 at 1:34 p.m. When asked what days he goes to dialysis, Resident #23 stated he is on a Monday - Wednesday - Friday schedule for 25 years. He was switched to a Tuesday - Thursday - Saturday schedule. However, has gone back to the Monday - Wednesday - Saturday schedule.

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When asked when he went back on the Monday - Wednesday - Friday schedule, Resident #23 stated he's been on it for two to three months."

An interview was conducted with LPN (licensed practical nurse) #2, on 11/15/18 at 4:20 p.m. When shown the above documentation on the TAR, LPN #2 was asked if the documentation was accurate. LPN #2 stated, "No, because he goes to dialysis on Mondays, Wednesdays and Fridays." She further stated the resident goes to dialysis in the morning. He returns to the facility on day shift, that's the first check. Then the next two shifts should be documenting that they are checking it. That then would complete the 24 hour check of the pressure dressing. LPN #2 stated, "The TAR needs to change to reflex the days the resident goes to dialysis."

The facility policy, "Nursing Documentation" documented in part, "3. Entries will be made as soon as possible after an event or observation is made."

The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received .....Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM

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F 842	Continued From page 77 #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m. When asked which professional standard of practice the facility follows, ASM #3 stated the facility uses Lippincott. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000500.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.	F 842		
F 880 SS=E	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	F 880		12/18/18

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F 880	Continued From page 78 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 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	F 880		

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F 880	Continued From page 79 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, staff interview, and facility document review, it was determined the facility staff failed to follow infection control practices in the laundry room. 1. One of four dryers had an excessive amount of dryer lint in the bottom of the machine. 2. A pair of used gloves were found behind the washing machines in the laundry room. The findings include: 1. Observation was made of the laundry room on 11/15/18 at 11:32 a.m. The large dryer was noted to have an excessive amount of dryer lint on the screen in the bottom of the machine. Piles of lint were also observed on the edges of the floor, where the machine sat on the floor on three of the four sides. When asked if this was an excessive amount of lint, other staff member (OSM) # 2, the director of environmental services, stated that it was an excess of lint. He further stated that the dryer in question had been out of order and was just fixed that morning. When asked if that is a reason for the lint to be excessive, OSM #2 stated, "No, Ma'am" The facility policy, "Laundry Policies and Procedures" documented in part, "d. Clean dryer lint every third load and at the end of each shift."	F 880	F-880 1. The center□s Laundry Room has been cleaned and gloves were immediately discarded appropriately. The Lint trap on the dryer was immediately cleaned of excessive lint. 2. All Residents are at risk. 3. SDC or designee to educate environmental services staff on the requirements for disposal of gloves in the laundry room and the policy on the cleaning the lint traps on the dryers in the laundry room. 4. DON or designee will audit Laundry room 2x daily for 1 week for proper disposal of gloves and cleanliness of lint traps in all dryers, then daily for 3 weeks, then review findings in following QA meeting. 5. Date of Compliance- 12.18.2018.	

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F 880	Continued From page 80 Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m. No further information was provided prior to exit. 2. Observation was made of the laundry room on 11/15/18 at 11:32 a.m. The washing machines were observed running. There were two blue used gloves found behind one of the two washing machines. When asked how they got there, the laundry staff could not explain it. When asked if the gloves should be back there, OSM #2 stated, "No, they used gloves for putting the dirty laundry into the machines." When asked where used gloves are to be disposed of, OSM #2 stated, "The trashcan." A policy was requested on the use and disposal of gloves in the laundry. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4 a regional nurse consultant were made aware of the above findings on 11/15/18 at 5:38 p.m. ASM #3 informed this surveyor that the facility did not have a policy on glove disposal. No further information was provided prior to exit.	F 880		