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	495379	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA MEADOWVIEW TERRACE	**184 BUFFALO ROAD CLARKSVILLE, VA 23927**

(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 Medicare/Medicaid standard survey was conducted 1/29/19 through 1/31/19. The facility's Emergency Preparedness Plan was found in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/29/2019 through 01/31/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 168 certified bed facility was 125 at the time of the survey. The survey sample consisted of 25 current resident reviews and three (3) closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		3/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/14/2019

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a dignified dining experience on one of five living units. Without seeking the resident's permission, a nurse administered an injection to a resident in front of others during the lunch meal on the Honeysuckle unit. In addition, a nurse stood beside two residents while feeding them their lunch. The findings include: A meal observation was conducted on the	F 550	Disclaimer: Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Sentara Meadowview Terrace of the truth of the facts alleged in this statement of deficiency and plan of correction. This plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance.	

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F 550	Continued From page 2 Honeysuckle unit on 1/29/19 from 11:45 a.m. until 12:30 p.m. On 1/29/19 at 11:53 a.m., licensed practical nurse (LPN) #6 was observed giving a male resident an injection in his right upper arm. The resident was seated at a table near the kitchenette with two other residents at the same table and multiple other residents and staff in the dining area. LPN #6 pulled back the resident's shirtsleeve then administered the injection with no prior permission from the resident. On 1/29/19 at 12:11 p.m., LPN #6 was observed feeding several bites of food to a resident while standing beside her. LPN #6 then went to the right side of another resident at the same table and fed this resident her lunch. LPN #6 stood beside this resident while feeding her the entire meal. There was no conversation with the residents other than encouraging them to eat their lunch. On 1/29/19 at 12:45 p.m., LPN #6 was interviewed about administering an injection in the dining room in front of other residents and standing while feeding residents. LPN #6 stated she was told she could administer medications in the dining room prior to the food service. When asked if this included injections, LPN #6 stated, "I took it to be any medicine." When asked about standing while feeding residents, LPN #6 stated she should have been seated when feeding the residents. LPN #6 stated that typically staff were seated when feeding residents. On 1/30/19 at 8:06 a.m., the unit manager (LPN #3) was interviewed about the injection given during the meal observation and standing when feeding residents. LPN #3 stated the nurse should always get the resident's permission prior	F 550	Meal Observation - injection 1. Nurse #6 was educated on policy and proper procedure related to administration of insulin in dining area during meal time. 2. Other residents receiving lunch time Insulin in dining room will be observed. 3. Re-education will be provided for all Nurses regarding the practice of proper procedure of administering Insulin injections at mealtime in the dining room. 4. Nurse Manager or designee will monitor lunch time insulin administration weekly for 4 weeks, and then monthly and report to Nursing QA. Meal Observation - standing 1. Nurse Manager reviewed with Nurse #6 to sit next to a resident when feeding a meal. 2. Staff will be observed during lunch time for standing while feeding residents. 3. Re-educate all nursing staff on practice of dignified dining experience to include sitting to feed residents. 4. Nurse Manager or designee will monitor a meal for 4 weeks, then monthly and report to Nursing QA.	

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F 550	Continued From page 3 to giving medications in the dining room. LPN #3 stated staff members were to assist/feed one resident at a time and were expected to sit at the table while feeding residents. These findings were reviewed with the administrator and director of nursing during a meeting on 1/30/19 at 4:30 p.m.	F 550		
F 656 SS=E	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		3/16/19

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F 656	Continued From page 4 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 resident interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to develop a CCP (comprehensive care plan) for the care and services for three of 28 residents in the survey sample, Resident #115, #106 and #101. 1. The facility staff failed to develop a CCP for Resident #115's AV (arteriovenous) graft (hemodialysis) access site for the provision of care and assessment with interventions. 2. Resident #106 did not have a care plan to address antipsychotic medications. 3. Resident #101 had no care plan developed regarding a leaking ileostomy and a skin rash/excoriation from contact with the leaking liquid stool. Findings include: 1. Resident #115 was admitted to the facility originally on 06/14/18. Diagnoses for Resident	F 656	1. The care plan for resident #115 (hemodialysis) access site for provision of care and assessments with interventions developed on 1/31/19 and placed in Care Plan book. 2. No other residents in the facility are on hemodialysis. 3. MDS Coordinators will be re-educated on Care Plan for access site. 4. Nurse Managers will monitor for Care Plan related to hemodialysis access site related to provision of care monthly and report to Nursing QA monthly. 1. Care plan for resident #101 developed, implemented and placed in Care Plan book. 2. No other residents in facility with ileostomy. 3. MDS Coordinators will include assessment of ileostomy for leakage and skin excoriation / rash in the Care Plan,	

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F 656	Continued From page 5 #115 included, but were not limited to: history of chronic alcohol use, DM (diabetes mellitus) requiring insulin, HTN (high blood pressure), seizure disorder, acquired absence of right below the knee amputation, and end stage renal failure (dependent on renal/hemodialysis). The most recent MDS (minimum data base), a quarterly assessment dated 01/07/19 documented the resident with a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. The resident was additionally assessed as receiving dialysis while a resident. The resident's most current full MDS, a significant change assessment dated 09/18/18 documented that the resident was a '13' cognitively and received dialysis as resident of the facility. Resident #115 was interviewed on 01/29/19 at 2:43 PM. The resident stated that he was on hemodialysis and goes for his treatments on Tuesday, Thursday and Saturday each week for approximately 2.5 to 3.5 hours. The resident stated that he had a port in his right chest for dialysis that was removed and he now has an AV hemodialysis access site in his left arm. The resident stated that it was doing ok. The resident was asked if the nurses here at the facility assess the access site in his left arm to ensure that there are no concerns with it, and was specifically asked if the nurses will feel the graft and listen to the graft with a stethoscope. The resident stated, "No, they don't check it here." The resident stated that it was checked at dialysis. The resident's clinical record was reviewed, to include the current POS (physician's orders set).	F 656	and re-educated on the importance of assessment. 4. QA Coordinator will monitor for care plan related to ileostomy leakage, skin excoriation / rash weekly for 4 weeks, then monthly and report to Nursing QA monthly. 1. Care plan for resident #106 was implemented and placed in care plan book. 2. Care plans for other residents on an antipsychotic medication were checked to ensure they were in place. All were in place. 3. MDS Coordinators or designee will access Framework via Neil Medical Pharmacy to check for residents given new antipsychotic orders Monday through Friday and prepare Care Plans for new antipsychotic orders. 4. MDS Manager will monitor residents on new antipsychotics to ensure care plans are in place weekly for 4 weeks, then monthly and report to Nursing QA monthly.	

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The most current POS signed by the physician was dated 12/01/18 through 12/31/18. The POS included orders for, "...fluid restriction 1500 ml [milliliters] daily...Check fistula site for s/s [signs and symptoms] of infection Q [every] shift and call [Name of Nephrologist] office with concerns..." No other orders were found in the resident's clinical record for the care of the resident's hemodialysis access site.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...ESRD [end stage renal disease] dependence on dialysis...chronic kidney disease...dialysis as ordered...renal diet as ordered..." No other care plan interventions, care and/or assessment information was documented for ongoing monitoring of the resident's AV graft.

On 01/30/19 at approximately 4:30 PM, the administrator and DON (director of nursing) were made aware in a meeting with the survey team. The administrator and DON were asked for a policy on care of a dialysis resident.

On 01/31/19 at approximately 8:30 AM, the DON presented a policy.

The policy titled, "Care of a Dialysis Resident" was reviewed and documented, "...To prevent complications pre and post dialysis treatment and to provide a safe environment...Bruit: Audible sound of blood flow present in the fistula...Thrill: Palpable "buzz" of blood flow present in the fistula...Fistula:...Graft:...Bruit and thrill must always be present...Pre Dialysis...indicate the presence bruit and/or thrill every shift...Do Not take blood pressures...Do Not start IVs...Do Not give injections...venipuncture...Post

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Dialysis...Check access and document the condition upon returning...condition of patient...Bruit and thrill will be checked each shift...check the access each shift for hematoma, swelling, or oozing or slight bleeding...DO NOT apply pressure dressings..."

The DON was made aware that none of this information regarding the care of the resident's dialysis catheter was on the resident's CCP. The DON was asked who develops and/or updates the CCP for residents. The DON stated that it is a disciplinary approach.

No further information and/or documentation was presented prior to the exit conference on 01/31/19 at 11:45 AM, to evidence that the facility staff developed a Comprehensive Care Plan for Resident #115, a resident on hemodialysis with an AV graft.
2. Resident #106 was admitted to the facility on 08/14/15. Diagnoses for Resident #106 included: Dementia with behavioral disturbance and major depression.

The most current MDS (minimum data set) was a quarterly assessment with an assessment reference date (ARD) of 1/3/19. Resident #106 was assessed with a cognitive score of 4, indicating severely cognitively impaired.

On 01/30/19 at 2:55 PM, Resident #106's medical record was reviewed. Physician orders dated 10/10/18 indicated a new order for (antipsychotic) Seroquel 25 MG twice daily. A new order dated 11/17/18 increased Seroquel to 50 MG twice daily. The most recent physician order dated 12/15/18 increased Seroquel to 75 MG twice daily.

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A review of Resident #106's comprehensive MDS dated 10/4/18 section "V" indicated that a care plan should be in place for "Psychotropic Drug Use." The most recent MDS with an ARD of 1/3/19, section "N" indicated that Resident #106 was taking antipsychotic medication daily.

Resident #106's care plan was reviewed and did not reference a care plan for antipstchotic medications.

On 01/30/19 at 3:34 PM, registered nurse (RN) #2 (MDS coordinator), assisted this surveyor to find the a care plan related to psychotic medications. RN #2 reviewed Resident #106's care plan and was unable to verify that a care plan was developed, verbalizing that a care plan for psychoactive medications should have been implemented but must have been missed.

On 01/30/19 04:22 PM the above information was presented to the director of nursing (DON) and administrator.

No other information was provided prior to exit conference on 1/31/19.
3. Resident #101 was admitted to the facility on 1/11/18 with a re-admission on 2/26/18. Diagnoses for Resident #101 included chronic atrial fibrillation, atherosclerotic heart disease, diabetes, high blood pressure, anemia, ileostomy due to diverticulosis, history of gastrointestinal bleed, neurogenic bladder and dementia. The minimum data set (MDS) dated 1/1/19 assessed Resident #101 with severely impaired cognitive skills and as totally dependent on one person for hygiene, bathing and toileting.

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On 1/30/19 at 9:25 a.m., accompanied by licensed practical nurse (LPN) #5, a bag change to Resident #101's ileostomy was observed. Resident #101 was immediately observed with a large amount of loose stool leaking from the ileostomy opening. Liquid stool was leaking from an approximate 3/4 inch gap where the ileostomy bag was not sealed around the stoma. The liquid stool was on the resident's skin around the ileostomy and had spilled onto the resident's right lower belly, in a crease under the right lower belly, and on the resident's right side and upper thigh. The resident's gown and incontinent brief were soiled with a small amount of stool. The skin around the edge of the ileostomy stoma was bright red with small amount of white colored skin present around the opening. There was a circular red area several inches from the stoma under the edge of the ileostomy bag flange. In the areas of the leaking stool, the resident's skin was blotchy and bright red/pink with excoriated spots. This redness and excoriation was also scattered in the crease under the right belly, on the top of the right thigh and along the right side of the belly. LPN #5 cleaned the liquid stool from the resident with soap/water, patted the skin areas dry and applied a new ileostomy bag. There was no medication, cream or any treatment applied to the excoriated skin. The resident expressed no pain or discomfort when the areas were cleansed. When asked how long the ileostomy had been leaking, LPN #5 stated the ileostomy bag was changed earlier this morning (1/30/19) on the night shift because it was leaking. LPN #5 stated the resident had experienced problems with a leaking ileostomy bag and skin excoriation "on and off."

Resident #101's clinical record documented a current physician's order to change the ileostomy

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F 656	Continued From page 10 bag every 3 days. Treatment records for January 2019 documented the ileostomy bag was changed every 3 days as ordered by the physician. The clinical record documented the following active physician orders regarding skin care related to the ileostomy: 4/2/18 - Nystatin Powder - Apply topically to stoma of ileostomy after cleansing area with soap and water, patting dry with each ostomy appliance change for yeast - as needed; 4/2/18 - Nystatin cream - Apply cream topically to groin and abdominal folds three times per day for yeast as needed; 4/12/18 - Calmoseptine ointment - Apply twice daily to abdominal area surrounding ileostomy after gently cleaning with soap and water, patting dry, as needed; 4/12/18 - Calmoseptine ointment - Apply to abdominal folds and groin after applying Nystatin for yeast/skin irritation/protection, as needed; and 8/18/18 - Triamcinolone ointment 0.1% - Apply to abdominal rash twice daily until healed, as needed. Resident #101's plan of care (revised 1/10/19) listed the resident had an ostomy due to history of partial colon removal. The ostomy care plan documented interventions to prevent infection and complications as, "Monitor ostomy site for swelling, pain, or redness and report promptly to MD [physician] with follow up as indicated...Ostomy care as need to prevent odors... Monitor output per MD orders and report any abnormalities..." There were no problems, goals and/or interventions included in the care plan related to the leaking ileostomy bag or the associated skin rash. There had been no ileostomy problems or interventions added to the care plan since 4/20/18. On 1/30/19 at 11:10 a.m., LPN #5 was	F 656		

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interviewed about any assessment and/or interventions regarding the leaking ileostomy and irritated skin. LPN #5 stated the resident had issues with excoriated skin on her belly for "quite awhile" and the excoriation "comes and goes." LPN #5 stated the resident sometimes "fondled" the ileostomy bag. LPN #5 was asked for any skin assessments or nursing notes indicating when the resident had excoriation or a leaking ileostomy bag. LPN #5 reviewed Resident #101's clinical record and did not locate any notes and/or assessments regarding the leaking ileostomy or skin excoriation.

On 1/30/19 at 2:00 p.m., the unit manager (LPN #3) was interviewed about Resident #101's leaking ileostomy and skin excoriation. LPN #3 stated the resident at one time had an abdominal binder to prevent her from "picking" at the ileostomy bag but it was not effective and was later discontinued. When asked how long the resident's ileostomy bag had been leaking and skin excoriated, LPN #3 stated, "I can't answer that. I don't know." LPN #3 stated the resident had issues with skin irritation "on and off" in the past but she did not know when this current excoriation started.

On 1/31/19 at 7:52 a.m., a certified nurses' aide (CNA #3) that cared for Resident #101 at times was interviewed. CNA #3 stated the resident's skin rash and redness "comes and goes" and had been that way for "quite awhile." CNA #3 stated she thought the nurses put cream on the rash at times. CNA #3 stated the ileostomy bag leaked "at times" but not all the time. CNA #3 stated the resident sometimes "messes" with the bag.

On 1/31/19 at 8:03 a.m., CNA #4 that routinely

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F 656	Continued From page 12	F 656		

cared for Resident #101 was interviewed. CNA #4 stated the resident's ileostomy had been leaking "on and off" ever since she had worked on this unit, which started in November 2018. CNA #4 stated the resident's skin rash gets worse then it gets better. When asked about the frequency of the ileostomy bag leaking, CNA #4 stated, "I would say occasionally."

On 1/31/19 at 9:00 a.m., the registered nurse (RN #4) responsible for MDS assessments and care plans was interviewed. RN #4 stated she was not aware of Resident 101's leaking ileostomy or skin excoriation so had therefore not added any problems, goals or interventions to the care plan. RN #4 stated she reviewed nursing notes and saw no documentation regarding ileostomy issues. RN #4 stated the last care plan meeting was held on 1/10/19 and staff members reported no problems regarding skin irritation or a leaking ileostomy.

The Lippincott Manual of Nursing Practice 10th edition on page 660 describes an ileostomy as a "...surgically created opening between the ileum of the small intestine and the abdominal wall to allow elimination of small bowel effluent..." This reference defines a stoma as, "...part of the intestine (small or large) that is brought above the abdominal wall to become the outlet for discharge of intestinal waste." Page 661 of this reference includes among possible complications of a stoma, "Peristomal skin breakdown from exposure to fecal output, allergic reaction to products, or infection, such as candidiasis." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 1/30/19 at 4:30 p.m.

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F 656	Continued From page 13 This was a complaint deficiency. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for treatment and care of skin integrity for one of 28, Resident #91. Resident #91 did not have physician ordered heel protectors on while in bed. The Findings Include: Resident #91 was admitted to the facility on 08/14/15. Diagnoses included: Muscle contractures, osteoarthritis, lower extermety	F 686	Resident #91 1. Prevalon Boots were placed on resident #91 at that time. 2. An audit was done for residents with orders for Prevalon Boots to observe them in place. 3. Staff will be re-educated on the placement of Prevelon Boots and their importance. 4. Nurse Manager will monitor for placement of Prevelon Boots weekly for 4 weeks, then monthly and report to Nursing QA monthly.	3/16/19

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F 686	Continued From page 14 edema, and stage 3 pressure ulcer to sacral area. The most current MDS (minimum data set) was a significant change assessment with an assessment reference date (ARD) of 12/26/18. Resident #91 was assessed with a cognitive score of 15, indicating cognitively intact. On 01/29/19 at 2:36 PM, Resident #91 was interviewed. Resident #91 was laying in bed; a pair of Prevlon boots (used to protect heels) were observed in a chair beside the bed. Resident #91 was asked if there were any open wound areas. Resident #91 verbalized that he had an open area to his bottom. After completing an interview with Resident #91, Resident #91's physician orders were reviewed. An order on the current physician order sheet dated 12/2/18 documented in part "Prevalon boots while in bed bilateral feet, check placement q (every) shift." On 01/29/19 at 3:45 PM, Resident #91 was asked if the staff put the protective boots on. Resident #91 verbalized the staff puts the boots on at night. On 01/29/19 at 3:48 PM, the certified nursing assistant (CNA #3) was interviewed regarding Resident #91's protective boots. CNA #3 verbalized that she had just picked up Resident #91 for the 3-11 shift. CNA #3 stated that she was under the impression that the prevalon boots were for when the Resident #91 wanted them on. This surveyor explained the physician order to CNA #3 and CNA #3 verbalized that she would place the heel protectors on Resident #91. At 01/29/19 at 4:01 PM, Resident #91 was observed	F 686		

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F 686	Continued From page 15 in bed with prevalon boots in place. On 01/30/19 at 2:10 PM, Resident #91's heels were observed with registered nurse (RN) #1. Resident #91's right heel had some cracked dry skin beginning to peel from heel, lotion was applied to both feet by RN #1. On 01/30/19 04:22 PM the above information was provided to the director of nursing and administrator during a surveyor/staff meeting. No other information was provided prior to exit conference on 1/31/19.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		3/16/19

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F 690	Continued From page 16 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to anchor the tubing for a Foley urinary catheter for one of 28 residents in the survey sample. Resident #101 did not have the Foley catheter tubing anchored to her thigh as ordered by the physician and required in her plan of care. The findings include: Resident #101 was admitted to the facility on 1/11/18 with a re-admission on 2/26/18. Diagnoses for Resident #101 included chronic atrial fibrillation, atherosclerotic heart disease, diabetes, high blood pressure, anemia, ileostomy due to diverticulosis, history of gastrointestinal bleed, neurogenic bladder and dementia. The minimum data set (MDS) dated 1/1/19 assessed Resident #101 with severely impaired cognitive skills and as totally dependent on one person for hygiene, bathing and toileting. On 1/30/19 at 9:25 a.m., accompanied by licensed practical nurse (LPN #5), Resident	F 690	1. For Resident #101, the anchor device to stabilizer catheter was applied. 2. Residents having catheters were assessed and all had anchor devices in place. 3. Re-educate nursing staff on use of catheter anchor devices and their role in applying, monitoring and reporting. 4. Nurse Managers will assess for anchor devices for Foley catheters weekly for 4 weeks, then monthly and report to nursing QA.	

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#101's Foley catheter tubing was observed. The urinary catheter tubing was not anchored in any manner to the resident's thigh. There was no "stat-lock" or any other device in place to stabilize or prevent pulling/pushing of the catheter tubing. LPN #5 was interviewed at this time about an anchor for the tubing. LPN #5 stated the tubing was supposed to be secured with a "stat-lock." LPN #5 looked about the bed and did not find the stat-lock device. LPN #5 stated she did not know why the catheter tubing was not anchored.

Resident #101's clinical record documented a physician's order dated 3/16/18 for a Foley urinary catheter due to a diagnosis of neurogenic bladder. A physician's order dated 1/22/19 required the Foley catheter tubing to be anchored to the resident's thigh with use of a "stat-lock" device with placement checked every shift. Resident #101's plan of care (revised 1/10/19) listed the resident was at risk of infection and retention from catheter use due to a neuromuscular bladder dysfunction. Included in interventions to prevent complications was "stat lock as ordered."

The Lippincott Manual of Nursing Practice 10th edition on page 781 documents regarding care of an indwelling catheter, "...Secure the indwelling catheter to patient's thigh using tape, strap, adhesive anchor, or other securement device...Properly securing the catheter prevents catheter movement and traction on the urethra...Pulling on the catheter may be painful. Backward and forward displacement of the catheter introduces contaminants into the urinary tract..." (1)

These findings were reviewed with the

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F 690	Continued From page 18 administrator and director of nursing during a meeting on 1/30/19 at 4:30 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 690		
F 691 SS=E	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and complaint investigation, the facility staff failed to assess and implement interventions for care of an ileostomy for one of 28 residents in the survey sample. Resident #101 was observed with a leaking ileostomy bag and red, excoriated skin in the area of the leaking stool. The facility failed to assess and implement interventions for the excoriated skin related to the leaking ileostomy. The facility staff failed to initiate and/or implement interventions to prevent stool leakage from the ileostomy that direct care staff stated had been ongoing for at least three months. The findings include: Resident #101 was admitted to the facility on	F 691	1. Resident #101 assessed by Wound Nurse. Orders were reviewed and revised by Wound Care Nurse and Nurse Practioner. Treatment initated as ordered. 2. No other residents with ileostomies in facility. 3. Nurses will be re-educated on assessment and care of ileostomy, skin care and documentation. The nurse will assess daily for leakage of bag, excoriation of skin and carry out intervention. The Wound Nurse and MD/NP will be notified of red excoriated skin. 4. The Wound Nurse will assess weekly for leakage and excoriated skin. Wound Nurse to monitor documentation weekly and report to Nursing QA monthly.	3/16/19

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1/11/18 with a re-admission on 2/26/18. Diagnoses for Resident #101 included chronic atrial fibrillation, atherosclerotic heart disease, diabetes, high blood pressure, anemia, ileostomy due to diverticulosis, history of gastrointestinal bleed, neurogenic bladder and dementia. The minimum data set (MDS) dated 1/1/19 assessed Resident #101 with severely impaired cognitive skills and as totally dependent on one person for hygiene, bathing and toileting.

On 1/30/19 at 9:25 a.m., accompanied by licensed practical nurse (LPN) #5, a bag change to Resident #101's ileostomy was observed. Resident #101 was immediately observed with a large amount of loose stool leaking from the ileostomy opening. Liquid stool was leaking from an approximate 3/4 inch gap where the ileostomy bag was not sealed around the stoma. The liquid stool was on the resident's skin around the ileostomy and had spilled onto the resident's right lower belly, in a crease under the right lower belly, and on the resident's right side and upper thigh. The resident's gown and incontinent brief were soiled with a small amount of stool. The skin around the edge of the ileostomy stoma was bright red with a small amount of white colored skin present around the opening. There was a circular red area several inches from the stoma under the edge of the ileostomy bag flange. In the areas of the leaking stool, the resident's skin was blotchy and bright red/pink with excoriated spots. This redness and excoriation was also scattered in the crease under the right belly, on the top of the right thigh and along the right side of the belly. LPN #5 cleaned the liquid stool from the resident with soap/water, patted the skin areas dry and applied a new ileostomy bag. There was no medication, cream or any

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treatment applied to the excoriated skin. The resident expressed no pain or discomfort when the areas were cleansed. When asked how long the ileostomy had been leaking, LPN #5 stated the ileostomy bag was changed earlier this morning (1/30/19) on the night shift because it was leaking. LPN #5 stated the resident had experienced problems with a leaking ileostomy bag and skin excoriation "on and off."

Resident #101's clinical record documented a current physician's order to change the ileostomy bag every 3 days. Treatment records for January 2019 documented the ileostomy bag was changed every 3 days as ordered by the physician. The clinical record documented the following active physician orders regarding skin care related to the ileostomy.

4/2/18 - Nystatin Powder - Apply topically to stoma of ileostomy after cleansing area with soap and water, patting dry with each ostomy appliance change for yeast - as needed

4/2/18 - Nystatin cream - Apply cream topically to groin and abdominal folds three times per day for yeast as needed

4/12/18 - Calmoseptine ointment - Apply twice daily to abdominal area surrounding ileostomy after gently cleaning with soap and water, patting dry, as needed

4/12/18 - Calmoseptine ointment - Apply to abdominal folds and groin after applying Nystatin for yeast/skin irritation/protection, as needed

8/18/18 - Triamcinolone ointment 0.1% - Apply to abdominal rash twice daily until healed, as

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needed

Resident #101's treatment record documented the ileostomy bag was last changed on 1/30/19 at 7:00 a.m. There was no nursing assessment in the clinical record of the resident's skin condition at the time of this bag change. Nursing notes made no mention of the leaking ileostomy bag or any description or interventions implemented regarding the leak or the excoriated skin. Nursing notes reviewed from November 2018 through 1/29/19 made no mention of a leaking ileostomy bag or any assessment of the resident's skin around the stoma or abdomen. Treatment records documented none of the as needed treatment orders listed above for skin care related to the ileostomy were implemented during December 2018 through 1/30/19. The treatment record for November 2018 documented the Triamcinolone 0.1% cream was applied on 1/5/18, 1/8/18 and 1/21/18. The Nystatin cream and Nystatin powder were applied on 1/5/18, 1/15/18 and 1/21/18. There were no nursing assessments documenting any description of the resident's skin and/or stoma related to the application of these as needed medications in November 2018. Resident #101's weekly skin assessments conducted on 1/8/19, 1/14/19 and 1/21/19 documented no skin problems.

Resident #101's plan of care (revised 1/10/19) listed the resident had an ostomy due to history of partial colon removal. The ostomy care plan documented interventions to prevent infection and complications as, "Monitor ostomy site for swelling, pain, or redness and report promptly to MD [physician] with follow up as indicated...Ostomy care as need to prevent odors... Monitor output per MD orders and report

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any abnormalities..." An intervention for an abdominal binder when in bed to keep the resident from picking at the bag was added on 4/20/18 and discontinued from the plan on 5/23/18. There was no mention of the resident's leaking ileostomy bag, skin rash or any other interventions to prevent bag leakage. There had been no ileostomy problems or interventions added to the care plan since 4/20/18.

On 1/30/19 at 11:10 a.m., LPN #5 was interviewed about any assessment and/or interventions regarding the leaking ileostomy and irritated skin. LPN #5 stated the resident had issues with excoriated skin on her belly for "quite awhile" and the excoriation "comes and goes." LPN #5 stated the resident sometimes "fondled" the ileostomy bag. LPN #5 was asked for any skin assessments or nursing notes indicating when the resident had excoriation or a leaking ileostomy bag. LPN #5 reviewed Resident #101's clinical record and did not locate any notes and/or assessments regarding the leaking ileostomy or skin excoriation. When asked why the as needed creams and/or powder were not administered, LPN #5 stated she went back after the ileostomy bag change this morning (1/30/19 at 9:25 a.m.) and applied the Triamcinolone cream but did not sign it off on the treatment record. LPN #5 did not know why medications were not administered when the bag was changed earlier in the morning (1/30/19 at 7:00 a.m.). LPN #5 documented no assessment of the resident's excoriated skin and leaking ileostomy present during the bag change on 1/30/19 at 9:25 a.m. LPN #5 stated they tried an abdominal binder in the past to prevent the resident from dislodging the bag but it was not comfortable for the resident and was discontinued. LPN #5 had no response when

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asked of any other interventions to prevent stool leakage from the ileostomy bag.

On 1/30/19 at 2:00 p.m., the unit manager (LPN #3) was interviewed about Resident #101's leaking ileostomy and skin excoriation. LPN #3 stated the resident at one time had an abdominal binder to prevent her from "picking" at the ileostomy bag but it was not effective and was later discontinued. When asked how long the resident's ileostomy bag had been leaking and skin excoriated, LPN #3 stated, "I can't answer that. I don't know." LPN #3 stated the resident had issues with skin irritation "on and off" in the past but she did not know when this current excoriation started.

On 1/31/19 at 7:52 a.m., a certified nurses' aide (CNA #3) that cared for Resident #101 at times was interviewed. CNA #3 stated the resident's skin rash and redness "comes and goes" and had been that way for "quite awhile." CNA #3 stated she thought the nurses put cream on the rash at times. CNA #3 stated the ileostomy bag leaked "at times" but not all the time. CNA #3 stated the resident sometimes "messes" with the bag.

On 1/31/19 at 8:00 a.m., the facility's wound nurse (LPN #4) was interviewed about any assessment or treatment of the resident's excoriated skin. LPN #4 stated the resident had been treated last year for excoriation but she was not aware of any recent issues with a leaking ileostomy or excoriation. LPN #4 stated nurses had not reported any concerns to her in the last several months about skin issues with Resident #101.

On 1/31/19 at 8:03 a.m., CNA #4 that routinely

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cared for Resident #101 was interviewed. CNA #4 stated the resident's ileostomy had been leaking "on and off" ever since she had worked on this unit, which started in November 2018. CNA #4 stated the resident's skin rash gets worse then it gets better. When asked about the frequency of the ileostomy bag leaking, CNA #4 stated, "I would say occasionally."

On 1/31/19 at 9:00 a.m., the registered nurse (RN #4) responsible for MDS assessments and care plans was interviewed. RN #4 stated she was not aware of any issues with Resident 101's leaking ileostomy or skin excoriation so had therefore not added any problems or interventions to the care plan. RN #4 stated she reviewed nursing notes and saw no documentation regarding ileostomy issues. RN #4 stated the last care plan meeting was held on 1/10/19 and staff members reported no issues regarding skin irritation or a leaking ileostomy.

The Lippincott Manual of Nursing Practice 10th edition on page 660 describes an ileostomy as a "...surgically created opening between the ileum of the small intestine and the abdominal wall to allow elimination of small bowel effluent..." This reference defines a stoma as, "...part of the intestine (small or large) that is brought above the abdominal wall to become the outlet for discharge of intestinal waste." Page 661 of this reference includes among possible complications of a stoma, "Peristomal skin breakdown from exposure to fecal output, allergic reaction to products, or infection, such as candidiasis [yeast]." (1)

These findings were reviewed with the administrator and director of nursing during a

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F 691	Continued From page 25 meeting on 1/30/19 at 4:30 p.m. This was a complaint deficiency. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 691		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to provide a diet per physician order for one of 28 residents in the survey sample, Resident #2.	F 692	1. Resident #2 had diet order changed to Regular since she was assessed to be able to eat with utensils without difficulty. 2. Residents who have orders for finger foods will be assessed for receiving these	3/16/19

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Facility staff failed to provide finger foods per physician order for Resident #2 at each meal.

Findings included:

Resident #2 was admitted to the facility on 12/07/2015 with diagnoses including, but not limited to: Dementia with psychosis, Alzheimer's Disease, Macular Degeneration, Insomnia, and Anxiety.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/11/19. Resident #2 was assessed as impaired in her short and long term memory and moderately impaired in her daily decision making skills.

Resident #2 was observed on 01/29/19 at approximately 12:00 p.m. with lunch that consisted of lasagna, broccoli and green beans. She was observed on 01/30/19 at 8:35 a.m. with breakfast that consisted of cereal with bananas, egg omelet, ham, toast and pudding.

Resident #2's clinical record was reviewed on 01/29/19 at 3:00 p.m. Her most recent POS (physician order sheet) dated 01/01/19 through 01/31/19 included a diet order, "...Diet: Finger Foods, Regular..."

LPN #2 (licensed practical nurse) was interviewed on 01/30/19 at 8:15 a.m. regarding Resident #2's dietary order for finger foods. LPN #2 stated, "Yea, they have gotten away from that. I don't know why."

Resident #2's dietary tickets for lunch and supper on 01/30/19 were reviewed with CNA (certified

F 692

foods.
3. a) Re-education will be done with staff on what constitutes "finger foods."
b) A list of available finger foods will be posted on steam tables.
4. Dietary Manager will monitor the service of finger foods being delivered for meals weekly for 4 weeks, then monthly and report to QA&I Committee quarterly.

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nursing assistant)#1. Resident #2's lunch ticket included, "pineapple, roll, pork-chops with gravy, potato casserole, collard greens"...her supper ticket included, "tossed salad, dressing-salad, cherry cobbler, pizza, broccoli-buttered..."

CNA #1, homemaker for Periwinkle Unit was interviewed on 01/30/19 at 8:50 a.m. regarding Resident #2's dietary order. CNA #1 stated, "I go by the ticket sent from the kitchen. I usually put her meats in a roll at lunch time. I do the same at supper. They don't send it [finger foods] from the kitchen."

The Dietary Manager (DM) was interviewed on 01/30/19 at 8:55 a.m. regarding Resident #2's finger foods diet order. The DM stated, "I send food from the kitchen and they should serve finger foods accordingly." The above mentioned meal tickets were reviewed with the DM. He stated, "I agree, this is not finger foods."

The Director of Non-clinical services also reviewed the meal tickets for Resident #2. She stated, "Maybe the pizza, but no this isn't finger foods."

The Dining Services Nutritional Assessments dated 10/25/18 and 01/24/19, completed by the registered dietitian included documentation that Resident #2 had a dietary order for a regular diet, finger foods.

Review of this resident's meal intake records revealed she was eating approximately 10-25% of all meals.

The comprehensive care plan (CCP) was reviewed and included: "...Original Date/Effective

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F 692	Continued From page 28 Date: 05/04/16, Reviewed: 01/24/19, Problems/Strengths: ...finger foods diet in order to promote self feeding. Goals: To be able to feed herself for as long as possible. Goal met and extended 04/24/19. Interventions: Effective Date: Provide Diet as Tolerated; Update Meal Preference; Give Resident Enough Time To Eat; Invite to All Food Related Activities; Review Diet Needs Every Quarter." The Administrator and DON (director of nursing) were informed of the above during an end of the day meeting on 01/30/19. No further information was received prior to the exit conference on 01/31/19.	F 692		
F 698 SS=E	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 and clinical record review, the facility staff failed to ensure care and services of a hemodialysis catheter access site was provided for one of 28 residents in the survey sample, Resident #115. The facility staff failed to assess Resident #115's AV graft (hemodialysis) access site for the provision of care, assessment and care planning. The facility staff were not assessing the resident's AV (arteriovenous) graft on a daily basis to ensure proper blood flow and/or assess for any	F 698	1. The Physician was notified immediately, order written to assess AV graft for Bruit and thrills every shift and for any changes.. 2. No other dialysis residents in facility. 3. Staff will be re-educated on the care of AV graft for dialysis, to include assessing Bruit and thrills, and any changes or potential complications. 4. Nurse Manager will monitor weekly for documentation of assessing AV graft, and report monthly to Nursing QA.	3/16/19

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changes or potential complications related to a hemodialysis access site.

Findings include:

Resident #115 was admitted to the facility originally on 06/14/18. Diagnoses for Resident #115 included, but were not limited to: history of chronic alcohol use, DM (diabetes mellitus) requiring insulin, HTN (high blood pressure), seizure disorder, acquired absence of right below the knee amputation, and end stage renal failure (dependent on renal/hemodialysis).

The most recent MDS (minimum data base), a quarterly assessment dated 01/07/19 documented the resident with a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as supervision with setup only for most all ADL's (activities of daily living). The resident was additionally assessed as receiving dialysis while a resident.

The resident's most current full MDS, a significant change assessment dated 09/18/18 documented that the resident was a '13' cognitively and received dialysis while a resident of the facility.

Resident #115 was interviewed on 01/29/19 at 2:43 PM. The resident stated that he was on hemodialysis and goes for his treatments on Tuesday, Thursday, and Saturday each week for approximately 2.5 to 3.5 hours. The resident stated that he had a port in his right chest for dialysis that was removed and he now has an AV hemodialysis access site in his left arm. The resident stated that it was doing ok. The resident was asked if the nurses at the facility assess the

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access site in his left arm to ensure that there are no concerns with it, and was specifically asked if the nurses will feel the graft and listen to the graft with a stethoscope. The resident stated, "No, they don't check it here." The resident stated that it is checked at dialysis.

The resident's clinical record was reviewed, to include the resident's current POS (physician's orders set). The most current POS signed by the physician was dated 12/01/18 through 12/31/18. The POS included orders for, "...fluid restriction 1500 ml [milliliters] daily...Check fistula site for s/s [signs and symptoms] of infection Q [every] shift and call [Name of Nephrologist] office with concerns..." No other orders were found in the resident's clinical record for the care of the resident's hemodialysis access site.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...ESRD [end stage renal disease] dependence on dialysis...chronic kidney disease...dialysis as ordered...renal diet as ordered..." No other care plan interventions were documented for the care and treatment of the resident's hemodialysis access site.

The resident's MARs/TARs (medication administration records/treatment administration records) were reviewed for the months of December 2018 and January 2019. No documentation was found to evidence that nursing staff were checking the resident's AV graft for "thrill and bruit" and/or assessing the site routinely.

On 01/30/19 at approximately 3:00 PM, LPN (Licensed Practical Nurse) #8 was asked about

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Resident #115's AV graft and how nurses monitor it. LPN #8 stated, "What do you mean?" The LPN was asked how is it checked to ensure that it is not exhibiting any signs and or symptoms of potential problems. LPN #8 stated "Well, we look at it to observe for signs and symptoms of infection." LPN #8 was asked if that was the only type of assessment. LPN #8 stated that she didn't understand what was being asked. The LPN was asked if she, along with other nurses check or have been checking the resident's AV graft for "thrill and bruit"; LPN #8 stated, "I'll have to get back to you." LPN #8 did not answer the question. LPN #8 was made aware that there was no physician's order for the care and assessment of the AV graft, there were not any care plan interventions for care, assessment and monitoring of the AV graft, and there was no documentation on the resident's MARs/TARs to evidence that the nursing staff were actually assessing this resident's AV graft daily. LPN #8 did not follow up with the above question regarding assessment.

On 01/30/19 at approximately 4:30 PM, the administrator and DON (director of nursing) were made aware in a meeting with the survey team. The administrator and DON were asked for a policy on care of a dialysis resident.

On 01/31/19 at approximately 8:30 AM, the DON presented a policy and nursing note.

The policy titled, "Care of a Dialysis Resident" was reviewed and documented, "...To prevent complications pre and post dialysis treatment and to provide a safe environment...Bruit: Audible sound of blood flow present in the fistula...Thrill: Palpable "buzz" of blood flow present in the

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fistula...Fistula:...Graft:...Bruit and thrill must always be present...Pre Dialysis...indicate the presence bruit and/or thrill every shift...Do Not take blood pressures...Do Not start IVs...Do Not give injections...venipuncture...Post Dialysis...Check access and document the condition upon returning...condition of patient...Bruit and thrill will be checked each shift...check the access each shift for hematoma, swelling, or oozing or slight bleeding...DO NOT apply pressure dressings..."

The nursing note presented was dated 01/30/19 and timed 3:40 PM and written by LPN #8. The nursing note documented, "...[name of staff] from dialysis reported to writer that resident's shunt started being used by dialysis...on 12/31/18... [name of dialysis staff] stated "we did patient teaching to resident to check for drainage, reddness [sic] bruit and thrill and to let someone know if he had any problems with it..."

The DON was made aware that the policy presented documented for staff to check the resident's thrill and bruit daily and was made aware of concerns that the facility nurses were not assessing the access site for this resident. The DON was asked if the nurses were checking the thrill and bruit for this resident and the DON stated, "No."

No further information and/or documentation was presented prior to the exit conference on 01/31/19 at 11:45 AM, to evidence that the facility staff were assessing the resident's graft by auscultation and/or palpation for pulse, bruit and thrill to assure adequate blood flow and that the access site was free from potential problems.

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, group interview, facility document review and staff interview, the facility staff failed to respond to call bells in a timely manner. During interviews, multiple residents stated they waited at times from 30 minutes to one hour for staff response to call bells.	F 725	1. Resident #81 was interviewed to determine if there is a particular time of day this occurs. He has also been working with Physical Therapy since 11/24/18 and Occupational Therapy since 11/26/18 on transfer, independent toileting, as well as other ADLs.	3/16/19

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F 725	Continued From page 34 The findings include: On 1/29/19 at 11:40 a.m., Resident #81 was interviewed about quality of care/life in the facility. When asked about staff response to call bells, Resident #81 stated he frequently waited 30 minutes for call bell response, especially when he was in the bathroom. Resident #81 stated he was able to get into the bathroom independently but required assistance for getting clothing back on after using the bathroom. Resident #81 stated he frequently waited 30 minutes or more for assistance from the bathroom, depending on which aides were working. Resident #81 stated he had talked with nursing about the slow response but had not seen the times improve. On 1/30/19 at 10:00 a.m., an interview was conducted with a group of seven cognitively intact residents regarding quality of care/life in the facility. All the residents in the group expressed concerns about slow call bell response. All the residents stated they waited at times at least 30 minutes for a staff member to respond. Several residents stated that sometimes a staff person would come promptly, state they would get the nurse or aide but nobody ever returned. One resident in the group stated that several weeks ago she waited almost one hour in the bathroom for an aide to assist her. The group stated they did not feel there were enough staff members at certain times. The group stated they had discussed slow call bell response in resident council meetings but had not seen much improvement. Resident council meeting minutes for November 2018, December 2018 and January 2019 listed	F 725	2. Nurse Managers or designees will interview additional cognitively intact residents on neighborhoods / households related to concerns about staff response times to call bells. 3. a) Rounding will occur every 2 hours to address concerns and requests. b) Nursing staff will be re-educated on every 2 hour rounding and prompt response to call bells. 4. Managers will conduct interviews concerning call bell responses with 3 cognitively intact residents weekly for 4 weeks, then monthly and report to Nursing QA monthly.	

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call lights under the nursing section as a topic of discussion.

On 1/31/19 at 9:45 a.m., a licensed practical nurse unit manager (LPN #3) was interviewed about call bell response on her unit. LPN #3 stated call bells were expected to be answered "as quick as possible." LPN #3 stated if staff members were busy helping other residents, such as transfers with a mechanical lift or passing medications, then it might take awhile for staff to respond to the call lights. LPN #3 stated, "We try to explain to the residents if there is a delay."

On 1/31/19 at 10:05 a.m., the director of nursing (DON) was interviewed about slow call bell response. The DON stated all staff members were expected to respond to activated lights. The DON stated staff members were expected to respond to the need or go get the required staff. The DON stated there might be more extended response times during meal service and medication pass times as staff members would be assisting residents with meals and/or giving required medications.

These finding were reviewed with the administrator and DON during a meeting on 1/30/19 at 4:30 p.m.

F 761 SS=D — Label/Store Drugs and Biologicals — F 761 — 3/16/19

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

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F 761	Continued From page 36 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, and staff interview, the facility staff failed to ensure expired biological's were not readily available for use on one of 5 units. Expired lab collection tubes were readily available for use on the Primrose unit. The Findings Include: On 01/30/19 at 10:15 AM, storage of medications and biological's were observed on the Primrose unit. Three lab collection tubes were observed by this surveyor and license practical nurse (LPN #1) to be expired and mixed in with lab tubes that were not expired. Two of the lab tubes had an expiration date of 6/30/18 and one lab collection tube had an expiration date of 5/31/18.	F 761	1. Expired tubes removed. 2. Other neighborhood / household storage areas were checked and no expired tubes were found. 3. a) Nurse Manager will add monthly lab tube expiration date checks to 3rd shift nurse check list. b) Nurses will be educated on change in procedure. 4. Nurse Managers will monitor monthly and report to Nursing QA monthly.	

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F 761	Continued From page 37 LPN #1 was interviewed concerning the finding. LPN #1 verbalized that all nurses should be checking for expiration dates and discarding any lab tubes that are expired so the tubes couldn't be used. On 01/30/19 at 4:22 PM, the above information was brought to the attention of the director of nursing (DON) and administrator during an end of day staff meeting. The DON and administrator were asked, the expectation for expired lab collection tubes available for use. The administrator verbalized that expired lab tubes should be sent back to the lab. At this time a policy regarding expired biological's was asked for. On 1/31/19 at 8:00 AM, the DON verbalized that there was not a policy regarding expired biologicals, but understood the potential that expired lab tubes could be mistakenly used. No other information regarding this concern was provided prior to exit conference on 1/31/19.	F 761		
F 806 SS=F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;	F 806		3/16/19

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F 806	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, group interview, and facility document review, the facility staff failed to ensure appealing, alternate food options of similar nutritive value were available for residents. The facility staff failed to provide appealing, alternate food options of similar nutritive value to residents who do not eat food that was initially served or had requested a different meal choice, and failed to ensure that the alternate food options were clearly communicated and/or documented for resident knowledge of optimum alternate food choices. Findings include: An initial tour and observation of the kitchen was conducted on 01/29/19 at 11:15 AM. During the initial observation food temperatures were completed on the lunch menu items. The DM (dietary manger) was asked what the alternate food items for today were available for residents. The DM stated that they (the facility) did not have alternate food items. The DM was asked if a resident doesn't like what is being served, what alternate food choices do they have. The DM stated that the residents can have a sandwich or soup and all they have to do is tell nursing and the nurse will call the kitchen to get that particular item. The DM stated that they, (the facility) do not prepare an alternate meal or menu items along with the regularly planned meals. During the lunch observation at noon on 1/29/19, Resident # 65 left the table where she was eating. A portion of her lunch was left uneaten. As she	F 806	1. A printed alternate menu is to be developed and implemented. 2. Nutrition Coordinator will interview residents to determine if they feel they are offered an appealing alternate at meal times, and during meal observations determine if alternates are offered. 3. a) Alternate menus to be developed with dietician. b) Homemakers/household associates will make rounds to offer alternates to residents prior to meals. c) Educate Dietary and Homemakers/Household Associate staff on availability of alternates. 4. Nutrition Coordinator will survey 10% of residents concerning menu alternates weekly for 4 weeks, then monthly and report to QA&I Committee quarterly.	

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passed by the surveyor, she was asked why she didn't eat all of her lunch. "You're not supposed to ask me that," she said. "If it had been good, I would have eaten it all." When asked if she had requested an alternate, she shook her head "No" and continued on to her room. At approximately 12:30 p.m. on 1/29/19 on the Honeysuckle Unit, the "Homemaker" on the unit, who was plating the food, was asked about alternates if a resident doesn't like what is being served. The Homemaker stated, "There is no menu...they just have to ask. If they want a ham sandwich, or a peanut butter and jelly, or soup, they can ask for it. I have to go to the kitchen and make it for them."

On 01/29/19 at 2:34 PM, Resident #115 was interviewed regarding food. The resident stated that if you don't like the food that is served, they (staff) will bring you a sandwich, soup, or a salad sometimes, but nothing like a hot meal.

On 01/29/19 at 3:11 PM, Resident #82 stated that she had lost some weight since being at the facility, has never really been a big eater, and has ulcerative colitis and has had it for 16 years. The resident stated that you can't eat everything or it will go right through you. The resident was asked why she didn't eat her lunch today. The resident stated, "I don't like the lasagna, I am not used to eating stuff like that." When the resident was asked if she asked for something else, the resident stated that "all they ever offer is a sandwich and I get tired of eating sandwiches."

A clinical record review was conducted on Resident #39 on 01/30/19 at approximately 10:00 a.m. A nursing note dated 10/12/18 and timed 6:00 PM documented, "Resident could not have

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chili that facility was having. Resident was offered a ham and cheese sandwich or turkey sandwich. Resident refused these choices she asked what other sandwiches we had, resident was told that we have grilled cheese but nurse knows this is not resident's favorite sandwich. Resident said "No" to grilled cheese. Resident was offered soup to go with her green beans and resident said yes to the soup, requested chicken noodle soup...soup was given...resident ate 100%..."

On 01/30/19 at 10:00 AM, a group meeting was conducted with seven cognitively intact residents. The group was asked about meal alternatives. The seven residents attending the group, all agreed and responded that they are not aware of any food alternatives and stated that if you don't like what is served or you don't eat what is served, you can get a sandwich or soup, but as far as any other alternate food items the group stated that they did not have any knowledge of them and they (residents) have not been provided those choices.

On 01/30/19 at 10:05 AM, the dietary manager (DM) was interviewed regarding alternate food choices. The DM stated that they do not fix alternates with meals, prior to or in advance, and that if a resident doesn't like what is on the menu or being served, the resident can request a sandwich or soup and it will be fixed at the time it is requested. The DM was asked if they had a policy on having alternate food items available and the DM stated that they did not have a policy and they (the facility) did not have a list with specified foods for alternate choices, but stated that he could write one up. The DM was asked if the RD (registered dietitian) was available, the DM stated that she (RD) was at the facility today.

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On 01/30/19 at 10:12 AM, the RD was interviewed and stated that she just started back in November, and really wasn't sure what the process was for alternate food items. The RD stated that it has been, that if a resident doesn't like what is served they can ask for something else. The RD further stated that (residents) can ask for something else, such as a grilled cheese. The RD and DM were asked how that information is communicated to the residents, how do the residents know what is available for alternates. The DM stated that the nurses will tell the residents. The DM and the RD both were asked again to look for any documentation and/or information regarding dietary choices, alternates with comparative nutritive value and communication to the residents of those choices.

The RD stated, "There is not policy that I am aware of." The RD was asked how does the kitchen decide what food alternates are going to be offered to the residents. The RD stated that she understood the question, but was not sure. The RD and DM again stated that there was not a list or location for listed food alternates to ensure residents know what is available. The DM stated that there is stuff on hand in our kitchen for sandwiches, soup, chicken tenders, and mozzarella sticks. The DM stated that the nurse will relay the food alternates verbally. The DM was made aware that the residents interviewed mentioned sandwiches as the only choice offered by staff as an alternate food choice. The DM again stated that there was not a documented list of the food available that can be alternates.

On 01/30/19 at 11:38 AM, the RD was interviewed again and stated that there was

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nothing in the office regarding a policy, but had reviewed the policy book in the administrator's office and found a policy dated January 17, 2017. The policy titled, "Resident Rights to make personal dietary, food and meal choices" was reviewed and documented, "...The facility will offer alternate food choice, should the primary menus not meet the resident's choice or preference...nourishing alternative meals and snacks will be provided to residents who want to eat at no-traditional times or outside of scheduled meal service times, consistent with the resident plan of care...the facility will offer periodic cultural and ethnic meal of choice, based on resident group recommendation..."

The RD stated that as far as she knows, there was not a list and the administrator stated that they (the facility) has never had one, that it has never been like that. The RD stated that if there is a written list, the DM would have to answer that question.

On 01/30/19 at 3:37 PM,a meeting was held with the dietary manager, RD and the dietary clerk, regarding the lack of alternate food choices and the lack of communication regarding the food choices, when the resident wishes to have some other type of food than what is being served on the daily menu.

On 01/31/19 at approximately 10:30 AM, the DON and the administrator were made aware of the above information.

No further information and/or documentation was provided prior to the exit conference on 01//31/19 at 11:45 AM.

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F 880	Continued From page 43	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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;	F 880		3/16/19

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F 880	Continued From page 44 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility staff failed to develop and implement a water management program to identify the risk of Legionella, and also failed to perform hand hygiene during meal service. 1. The facility staff failed to develop and implement a water management program to identify the risk of Legionella.	F 880	Water Management Program 1. The development of the Water Management Program started on 2/1/18. On 2/26/19 a contractor familiar with our building's water flow and air flow systems completed his evaluation, and he created the Sentara Meadowview Domestic Water System Flow Diagram and the Domestic Water System Details in text, explaining	

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F 880	Continued From page 45 2. A nurse failed to perform hand hygiene between residents during a meal observation on the Honeysuckle unit. Findings include: 1. On 1/29/19 at 1:30 p.m. the facility administrator was asked for the Legionella identification program. The administrator stated she would get with staff responsible and bring to the conference room. On 1/30/19 at 2:30 p.m. the non-clinical services director, other staff (OS) # 2, came to the conference room to ask what was needed. OS # 2 was told the Legionella water management protocol was needed for review. OS # 2 stated "I think that's in the Emergency Preparedness book." OS # 2 then left the room and returned a few minutes later stating "You're correct; what's in the Emergency book isn't for Legionella...so here's what I have. I have a copy of the toolkit I downloaded from the internet, but there's no risk assessment done, and no water flow diagram to identify where Legionella could possibly grow. I do have a copy of testing that was done last January 2018 and showed no growth of Legionella. I also have a quality assurance plan for the development of a Legionella program. The staff who started that program is no longer working here. I had originally set the date of completion as June 2019, but now that we're discussing it I think I need to move that date to 30-45 days from now..." The administrator and DON (director of nursing) were advised of the above findings during an end of the day meeting 1/30/19 beginning at 4: 15	F 880	how the water supply enters the building and the designated flow points. 2. Same as step #1. 3. The development of the Water Management Program is in progress. The Water System Flow Diagram and Water System Details have been completed as part of our Water Management Program. Staff education on the Water Management Program will be completed upon completion of the plan. 4. The Maintenance Tech or designee will report on the elements of the Water Management Program procedures to the Non-clinical Director and to the Safety Committee bi-monthly. 1. Nurse #6 was re-educated on proper hand washing during meals. 2. Mealtime observations were conducted to identify any other staff failing to wash hands or use hand sanitizer between residents. 3. a) Nursing staff will complete hand washing module in Relias training. b) Nurse Managers will review hand washing requirements during staff meetings. 4. Meal time observations will be done by manager concerning hand washing between residents weekly for four weeks, then monthly and report to Nursing QA monthly.	

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p.m.

No further information was provided prior to the exit conference.

2. A meal observation was conducted on the Honeysuckle unit on 1/29/19 from 11:45 a.m. until 12:30 p.m.

On 1/29/19 at 12:11 p.m., licensed practical nurse (LPN) #6 was observed feeding a resident. LPN #6 handled the resident's fork and cup while feeding her at least three bites of food. LPN #6 handed the fork to the resident and told her to continue eating her food. Without performing hand hygiene, LPN #6 went immediately to another resident at the table and began feeding her lunch. While assisting this resident, LPN #6 handled the resident's utensils, cup, bottle of supplement in addition to touching the resident's wheelchair and patting the resident on the shoulder.

On 1/29/19 at 12:45 p.m., LPN #6 was interviewed about the lack of hand hygiene observed between the two residents during the lunch observation. LPN #6 stated she should have washed her hands between contact with residents.

On 1/30/19 at 8:06 a.m., the unit manager (LPN #3) was interviewed about hand hygiene during meals. LPN #3 stated hand sanitizer was available in the dining area and staff members were expected to wash and/or sanitize hands between contact with residents.

The facility's policy titled Handwashing/Hand Hygiene (undated) stated, "This facility considers hand hygiene the primary means to prevent the

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F 880	Continued From page 47 spread of infections...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, and visitors...Use an alcohol-based hand rub...Before and after direct contact with residents...Before and after assisting a resident with meals.. These findings were reviewed with the administrator and director of nursing during a meeting on 1/30/19 at 4:30 p.m.	F 880		