STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING ______ B. WING ______	C 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 01/15/19 through 01/17/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Six complaints was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey was conducted 01/15/19 through 01/17/19. Six complaints were investigated during the survey. 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 117 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 7 closed record reviews.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral	F 622		2/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/07/2019

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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status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:

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F 622	Continued From page 2 (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide the receiving provider the following information: contact information of the practitioner who was responsible for the care of the resident; resident representative information, including contact information; advance directive	F 622	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of	

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Continued From page 3

information; special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to: treatments and devices (oxygen, implants, IVs, tubes/catheters); precautions such as isolation or contact; special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; the resident's comprehensive care plan goals; and all information necessary to meet the resident's needs, which includes, but may not be limited to: resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; medications (including when last received); and most recent relevant labs, other diagnostic tests, and recent immunizations for 2 of 31 residents (Resident #86 and Resident #113).

The findings included:

1. The facility staff failed to ensure the receiving provider received the accurate date of the transfer and the current comprehensive care plan goals for Resident #86. There was not an assessment in the progress notes on 12/18/18 prior to Resident #86's transfer to the hospital to include the reason for the transfer or any documentation of the clinical information sent to the receiving provider or information provided to the resident.

Resident #86 was admitted to the facility 9/28/16 and readmitted 7/24/17 with diagnoses that included but not limited to non-traumatic subarachnoid hemorrhage, hypertension, major depressive disorder, gastroesophageal reflux disease, cardiomyopathies, psoriasis, hemiplegia

F 622

Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.

F 622

1. Resident #86 was treated at receiving facility and readmitted. Resident #113 no longer resides in the facility. Documentation is present in the clinical record of current residents that have been transferred to include contact information of practitioner, Resident representative contact information, advance directive information, special instructions, comprehensive care plan goals, and all other necessary information
2. Current residents who were transferred in the last 14 days were reviewed to ensure transfer form completion to include all required information. Corrections were made as necessary
3. Current licensed nursing staff were educated regarding transfer policy to include all required information and sending to receiving facility. Transfer form and other necessary information will be sent to receiving provider at the time of transfer. Nursing leadership will review residents transferred weekly X 4 to ensure accuracy of transfer information. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for one quarter

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and hemiparesis, seizures, anemia, insomnia, and dysphagia.

Resident #86's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

During the resident interview on 1/16/19 at 11:08 a.m., Resident #86 was asked about hospitalizations. Resident #86 stated she had a seizure and was sent to the hospital. Resident #86 was unable to recall the date.

The surveyor interviewed registered nurse #1on 1/17/19 at 10:38 a.m., R.N. #1 was asked when Resident #86 was sent to the hospital and what information was provided to the receiving facility. R.N. #1 stated Resident #86 was sent to the emergency room on 12/18/18. There were no progress notes for 12/18/18 prior to Resident #86's transfer to the hospital-only a note when the resident returned. R.N. #1 stated an assessment should have been done but the R.N. was unable to locate one. R.N. #1 stated a medication administration record (MAR), transfer form, recent discharge summary, progress notes, labs if pertinent, face sheet, code status and DNR (do not resuscitate) if they have one are sent. R.N. #1 stated the nurses don't usually send a care plan with them. He stated a change of condition form should be done but he was unable to locate one.

The transfer form was reviewed with RN #1. The date of transfer is incorrect-read 8/18/17. RN #1 was unable to explain the reason for the incorrect date. Corporate RN #2 stated maybe the person

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F 622	Continued From page 5 clicked the wrong date. The incorrect date was found on page 1 and page 2 of the transfer form. The surveyor requested the facility policy on transfer/discharges on 1/17/19. The policy titled "Notice of Transfer/Discharge" read in part "2. Verify that the patient's medical record provides supporting documentation by appropriate interdisciplinary disciplines related to reasons for discharge." The surveyor informed corporate registered nurse #1 of the above concern on 1/17/19 at 2:30 p.m. No further information was provided prior to the exit on 1/17/19. 2. For Resident #113, the facility staff failed to provide contact information of the practitioner responsible for the care of the Resident, Resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate, and copy of comprehensive care plan goals to receiving facility when Resident #113 was transferred. Resident #113 was admitted to the facility on 06/23/2018. Diagnoses included, but were not limited to, aftercare following joint replacement surgery, hypertension, and osteoarthritis of the left hip. Section C (cognitive patterns) of Resident #113's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/24/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.	F 622		

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F 622	Continued From page 6 On 01/17/19 the surveyor reviewed Resident # 113's progress notes. It contained health status note dated 06/24/18 at 8:44pm that read in part: "... Pt. (patient) ask to go to the hospital and new rehabilitation center. On call doctor was contacted and he said "send her out" ...." On 01/17/19 at 9:38am, the DON (director of nursing) provided the surveyor with a copy of a "Notice of Transfer/Discharge Form" that was provided to Resident #113 upon transfer to the emergency room on 06/24/18. The surveyor reviewed the transfer form and could not locate any documentation on the form that indicated the appropriate Resident information and care plan goals were sent with Resident #113 upon transfer to the hospital. On 01/17/19 at 9:40 am, the surveyor spoke to the DON and asked if Resident #113's health information and/or a copy of the comprehensive care plan goals. The DON stated that a interact form or care plan goal were not sent with Resident #113 upon transfer to hospital on 06/24/18 because she was requesting to leave the facility. The regional nurse consultant was made aware of issue on 01/17/19 at 2:30pm. No further information regarding this issue was provided to the survey team prior to the exit conference on 01/17/19.	F 622		
F 623 SS=D	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	F 623		2/19/19

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F 623	Continued From page 7 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon

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F 623	Continued From page 9 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, the facility staff failed to provide written notice of transfer/discharge to one of 31 residents (Resident #86). The findings included: The facility staff failed to provide a written transfer/discharge notice to Resident #86 when the resident was transported to the hospital 12/18/18. Resident #86 was admitted to the facility 9/28/16 and readmitted 7/24/17 with diagnoses that included but not limited to non-traumatic subarachnoid hemorrhage, hypertension, major depressive disorder, gastroesophageal reflux disease, cardiomyopathies, psoriasis, hemiplegia and hemiparesis, seizures, anemia, insomnia, and dysphagia. Resident #86's quarterly minimum data set (MDS) assessment with an assessment	F 623	F 623 1. Written notice of transfer was provided to Responsible Representative for Resident #86 1/18/2019 2. Current residents who were transferred in the last 14 days were reviewed to ensure written notices were provided. Corrections were made as necessary. 3. Nursing leadership and Medical records staff were educated regarding requirement to send written notices of transfer. Medical records will review transfers weekly X4 to ensure written notices sent. DON will review transfers weekly X 4 to ensure completion. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for one quarter.	

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reference date (ARD) of 1/2/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

During the resident interview on 1/16/19 at 11:08 a.m., Resident #86 was asked about hospitalizations. Resident #86 stated she had a seizure and was sent to the hospital. Resident #86 was unable to recall the date. Resident #86 was her own responsible party per the admission record in the electronic clinical record.

The surveyor interviewed registered nurse #1 on 1/17/19 at 10:38 a.m. R.N. #1 was asked when Resident #86 was sent to the hospital and what information was provided to the resident and/or resident representative. R.N. #1 stated Resident #86 was sent to the emergency room on 12/18/18. There were no progress notes for 12/18/18 prior to Resident #86's transfer to the hospital-only a note when the resident returned. R.N. #1 stated the transfer form was sent with the resident but a copy was not usually given to the resident.

The transfer form was reviewed with RN #1. The date of transfer is incorrect. The transfer form was dated 8/18/17. RN #1 was unable to explain the reason for the incorrect date. Corporate RN #2 stated maybe the person clicked the wrong date. The incorrect date was found on page 1 and page 2 of the transfer form.

The director of nursing was interviewed about notification to the ombudsman on 1/17/19 at 9:00 a.m. The DON stated once a month the ombudsman was informed of all the transfers/discharges.

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F 623	Continued From page 11 The surveyor requested the facility policy on transfer/discharges on 1/17/19. The policy titled "Notice of Transfer/Discharge" read in part "2. Verify that the patient's medical record provides supporting documentation by appropriate interdisciplinary disciplines related to reasons for discharge." The surveyor informed corporate registered nurse #1 of the above concern on 1/17/19 at 2:30 p.m. No further information was provided prior to the exit on 1/17/19.	F 623		
F 625 SS=D	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 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	F 625		2/19/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 12 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, facility document review, and clinical record review, the facility staff failed to provide bed hold information to 5 of 31 residents when transported to acute care facilities (Resident #86, Resident #113, Resident #21, Resident #50 and Resident #67). The findings included: 1. The facility staff failed to provide written information to Resident #86 of the bed hold policy before the resident was transported to an acute care hospital on 12/18/18. Resident #86 was admitted to the facility 9/28/16 and readmitted 7/24/17 with diagnoses that included but not limited to non-traumatic subarachnoid hemorrhage, hypertension, major depressive disorder, gastroesophageal reflux disease, cardiomyopathies, psoriasis, hemiplegia and hemiparesis, seizures, anemia, insomnia, and dysphagia. Resident #86's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. During the resident interview on 1/16/19 at 11:08 a.m., Resident #86 was asked about	F 625	F 625 1. Residents #86, #21, and #67 returned to the facility. Residents #50 and #113 no longer reside in the facility. Documentation is present in the clinical record of current residents that have been transferred regarding bed retention arrangements. 2. Current residents who were transferred in the last 14 days were reviewed to ensure bed hold offered in writing at the time of transfer. Corrections were made as necessary. 3. Current licensed nursing staff and admissions staff were educated regarding bed hold policy and procedures for notification and documentation at the time of transfer. Admissions staff will review residents transferred weekly X 4 to ensure accuracy of bed hold documentation. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for one quarter.	

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hospitalizations. Resident #86 stated she had a seizure and was sent to the hospital. Resident #86 was unable to recall the date.

The surveyor interviewed registered nurse #1on 1/17/19 at 10:38 a.m., R.N. #1 was asked when Resident #86 was sent to the hospital and what information was provided to the receiving facility. R.N. #1 stated Resident #86 was sent to the emergency room on 12/18/18. There were no progress notes for 12/18/18 prior to Resident #86's transfer to the hospital-only a note when the resident returned. R.N. #1 stated an assessment should have been done but the R.N. was unable to locate one. R.N. #1 stated a medication administration record (MAR), transfer form, recent discharge summary, progress notes, labs if pertinent, face sheet, code status and DNR (do not resuscitate) if they have one are sent. R.N. #1 stated the nurses don't usually send a care plan with them. He stated a change of condition form should be done but he was unable to locate one. R.N. #1 was asked about bed holds. R.N. #1 stated the nurse doesn't usually handle that.

The surveyor interviewed the admissions director on 1/17/19 at 10:00 a.m. if a bed hold was offered to Resident #86 when the resident was transported to the hospital on 12/18/18. The admissions director stated he would check.

The director of nursing (DON) informed the surveyor on 1/17/19 at 10:15 a.m. that a bed hold had not been offered to Resident #86. The surveyor requested the facility policy on bed holds.

The surveyor reviewed the facility policy titled "Bed Reserve" on 1/17/19. The policy read in

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part: "The Admissions Director will ensure the proper documentation is executed for any patient desiring to voluntarily reserve bed. Procedure: 1. The Admissions Director must establish contact with the patient and/or responsible agent to determine bed retention arrangements once the patient's hospitalization has been confirmed."

The surveyor informed corporate registered nurse #1 of the above concern on 1/17/19 at 2:30 p.m.

No further information was provided prior to the exit on 1/17/19.

5. For Resident #67 the facility staff failed to offer a bed hold when Resident was transferred to the hospital

Resident #67 was admitted to the facility on 10/09/13 and readmitted on 12/17/18. Diagnoses included but not limited to hypertension, pneumonia, hyperlipidemia, hemiplegia, seizure disorder, anxiety, depression, and bipolar disorder.

The most recent MDS (minimum data set) with an ARD of 12/26/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #67's clinical record was reviewed on 01/16/19. It contained a notice of transfer/discharge that indicated the Resident had been transferred to the hospital on 12/11/18. The surveyor could not locate information that indicated a bed hold was offered to Resident.

Surveyor spoke with the admissions director on 01/17/19 at approximately 0950. Admissions

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director stated that Resident #67 was not offered a bed hold because the facility was not going to utilize her room. Admissions director also stated that the facility does not normally offer bed holds to long-term care Residents unless they are out of the facility longer than 7 days. Admissions director stated that after a Resident has been out of the facility between 3 to 7 days, a bed hold would then be offered.

The admissions director provided the surveyor with a copy of facility policy entitled "Bed Reserve" on 01/17/19 at approximately 1130. This policy read in part "Policy number 601- 3. Hospitalization/Observation - Medicare and Medicaid programs do not pay to hold beds in the Health & Rehabilitation Center when a patient is hospitalized overnight. Consequently, whenever any patient (regardless of payer source) is transferred from the Health & Rehabilitation Center and is admitted for overnight hospitalization/observation (defined as being absent from the Health & Rehabilitation Center for more than 24 hours), the patient and or the responsible representative (or hospital) must pay to hold the bed if the patient wishes to ensure that he/she can return to the bed he/she has been occupying." and "Policy number 602-1 The Admissions Director must establish contact with the patient and/or responsible agent to determine bed retention arrangements once the patient's hospitalization has been confirmed".

The concern of not offering a bed hold was discussed with the administrative team during a meeting on 01/16/19 at approximately 1710.

No further information was provided prior to exit.
2. For Resident # 113, the facility staff failed to

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F 625	Continued From page 16 provide written bed hold notification when Resident #113 was transferred to the local hospital. Resident #113 was admitted to the facility on 06/23/18. Diagnoses included, but were not limited to, aftercare following joint replacement surgery, hypertension, and osteoarthritis of the left hip. Section C (cognitive patterns) of Resident #113's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/24/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. On 01/17/19 the surveyor reviewed Resident # 113's progress notes. It contained health status note dated 06/24/18 at 8:44pm that read in part: " ...Pt. (patient) ask to go to the hospital and new rehabilitation center. On call doctor was contacted and he said "send her out" ...." On 01/17/19 at 10:04am the surveyor spoke to the admission's director. The admission's director voiced that Resident #113 requested placement to an alternate facility in ED (emergency department) that is why she was not offered a bed hold. The regional nurse consultant was made aware of issue on 01/17/19 at 2:30pm. No further information regarding this issue was provided to the survey team prior to the exit conference on 01/17/19. 3. For Resident #21, the facility staff failed to provide written bed hold notification to Resident	F 625		

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F 625	Continued From page 17 #21's responsible party when Resident #21 was transferred to the local hospital. Resident #21 was admitted to the facility on 07/03/18. Diagnoses included, but were not limited to, type 2 diabetes, cerebrovascular disease, major depressive disorder, hypertension, gangrene acquired absence of the right leg, and peripheral vascular disease. Section C (cognitive patterns) of Resident #21's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/09/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. On 01/17/19 at 9:38am, the DON (director of nursing) provided the surveyor with a copy of an "eINTERACT Transfer Form" that was provided to Resident #21 upon transfer to the local hospital for a scheduled procedure on 11/20/18. The surveyor reviewed Resident # 21's clinical record and could not locate documentation that indicated that Resident #21's responsible party was offered a bed hold upon Resident #21's admission to the local hospital on 11/20/18. On 01/17/19 at 9:47am the surveyor spoke to the admission's director. The admission's director voiced that he attempted to contact Resident #21's responsible party via phone to offer bed hold and was not successful reaching responsible party. The admission's director stated that Resident #21's responsible party was not offered a bed hold in writing. The regional nurse consultant was made aware of issue on 01/17/19 at 2:30pm.	F 625		

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No further information regarding this issue was provided to the survey team prior to the exit conference on 01/17/19.

4. For Resident # 50, the facility staff failed to provide written bed hold notification when Resident # 50 was transferred to the local hospital.

Resident #50 was admitted to the facility on 11/15/18. Diagnoses included, but were not limited to, orthostatic hypotension, chronic obstructive pulmonary disease, muscle weakness, urinary retention, and hypokalemia.

Section C (cognitive patterns) of Resident #50's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/05/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

On 01/17/19 the surveyor reviewed Resident #50's progress notes. The clinical record contained a progress note dated 12/19/18 at 7:36am that read in part, "Resident was admitted to local hospital for low blood pressure and elevated heart rate".

The surveyor could not locate documentation in Resident #50's clinical record that indicated that Resident # 50 was offered a bed hold upon admission to the local hospital on 12/19/18.

On 01/17/19 at 11:26am the surveyor spoke to the admission's director. The admission's director voiced that he offered a bed hold at Resident #50's bedside the next day at the local hospital,

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F 625	Continued From page 19 not at the time of transfer and not in writing. The regional nurse consultant was made aware of issue on 01/17/19 at 2:30pm. No further information regarding this issue was provided to the survey team prior to the exit conference on 01/17/19.	F 625		
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, resident and staff interview and record review it was determined the facility staff failed to provide sufficient ADL (activities of daily living) care for 2 of 24 residents in the survey sample (Residents #33 and #86. ~ Failed to set-up food tray for Resident #33. ~ Failed to provide mouth care for Resident #86. Findings: 1. Resident #33 was admitted to the facility on 9/29/15. Her diagnoses included gastro-esophageal reflux, diabetes, anxiety and cancer. Resident #33's latest MDS (minimum data set) assessment, dated 11/23/18, coded the resident with slightly impaired cognitive ability. She was coded for supervision, with a one-person physical assist for eating.	F 677	F 677 1. Resident #86 received mouth care and shower after surveyor observation and is currently receiving mouth care daily and showers per schedule. Resident #33□s meal tray was set up after surveyor observation and is currently receiving assistance with tray set up daily for meals, care plan reviewed. 2. Current residents were reviewed during mealtime to ensure appropriate tray set up to include opening and uncovering items. Corrections were made as necessary. 3. Current licensed nursing staff and certified nursing assistants were educated regarding tray set up at mealtimes. Trays will be served and set up based on individual resident activity of daily living need and requests. Nursing leadership will observe a 10% sample of trays	2/19/19

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Resident #33's CCP (comprehensive care plan), reviewed and revised 12/4/18, documented the resident had an ADL self-care performance deficit due to weakness. The interventions to staff for eating were "The resident requires assistance and may need to be fed."

On 01/15/19 at 01:03 PM Resident # 33 was observed in her room. She was eating her lunch unassisted. Her pie and salad were observed to still be still covered with plastic wrap. No one had put the salad dressing on her salad. The bread was still in the wrapper and the butter had not been not opened or spread on bread.

The surveyor asked the resident if she needed help setting up the food on her tray. She responded by picking up the salad and asking the surveyor to unwrap it, because she could not do it.

The surveyor went into the hallway and asked LPN I to assist with this task. LPN I came into the room and finished setting up the tray for Resident #33. The facility policy for nursing procedures during meal delivery were reviewed. It contained, "Nursing will assist the patient with tray set-up as necessary (open milk and juice, open condiments, cut meat, butter bread, etc.

The facility administrator was informed 1/16/19 at 4:00 PM. No additional info was provided.
2. The facility staff failed to provide oral mouth care and showers to Resident #86.

Resident #86 was admitted to the facility 9/28/16 and readmitted 7/24/17 with diagnoses that included but not limited to non-traumatic subarachnoid hemorrhage, hypertension, major

Provider's Plan of Correction (F 677, continued):

passed during one mealtime a day 5 times weekly X 4 weeks. to ensure items opened and uncovered as needed. Any issues will be corrected immediately at the time of identification
4. Process will be reviewed in QA committee for one quarter.

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depressive disorder, gastroesophageal reflux disease, cardiomyopathies, psoriasis, hemiplegia and hemiparesis, seizures, anemia, insomnia, and dysphagia.

Resident #86's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section G Functional Status assessed the resident to require extensive assistance of one person for personal hygiene. Resident #86 was assessed to be totally dependent on one person for bathing.

Resident #86's current comprehensive care plan was reviewed 1/16/19. A focus area that resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) hemorrhagic stroke. Created on 9/29/16. Revision on 7/24/17. Interventions: Provide sponge bath when a full bath or shower cannot be tolerated. The resident needs assist with showers. A second focus area for oral/dental health problems stained teeth, dental caries r/t poor nutrition, history of poor oral hygiene, stained teeth from iron use. Interventions: Provide mouth care as per ADL personal hygiene.

The surveyor interviewed the resident on 1/16/19 at 11:01 a.m. The surveyor asked the resident when her teeth were last brushed. Resident #86 stated her teeth hadn't been brushed in several days. The surveyor interviewed certified nursing assistant #3 if mouth care had been done this morning. C.N.A. #3 stated mouth care had not been done this morning. Also during the interview, Resident #86 stated she had not been getting showers. Resident #86 stated she

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received a bed bath the previous night.

The surveyor reviewed the personal hygiene records for January 2019. The ADL (activities of daily living) record had no documentation that mouth care was provided 1/3/19 evening shift, 1/8/19 and 1/9/19 day shift, and 1/12/19 and 1/13/19 day shift.

The surveyor reviewed the shower documentation for the past 90 days beginning 11/1/18. The surveyor and registered nurse #1 reviewed the ADL-showers and bed baths.
For the week 11/1/18-11/3/18, there were no baths or showers given.
For the week of 11/25/18-12/1/18, Resident #86 did not receive any showers. Resident #86 was given 2 bed baths this week on 11/27/18 and 11/30/18.
For the week of 12/15/18-12/22/18, Resident #86 received one shower on 12/21/18 and no bed baths.
For the week of 12/22/18-12/29/18, Resident #86 received a bed bath on 12/25/18 and one shower on 12/28/18.
For the week of 12/30/18-1/5/19, Resident #86 did not receive any showers and only received one bed bath on 1/4/19.

Upon review of the showers and bed baths, registered nurse #1 stated the resident did not receive showers/bed baths as needed by the dependent resident.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 1/16/19 at 5:09 p.m.

No further information was provided prior to the

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F 677	Continued From page 23 exit conference on 1/17/19.	F 677		
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, facility document review, and clinical record review, the facility staff failed to provide one of 31 residents (Resident #101) with pressure ulcer treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The findings included: The facility staff failed to provide pressure ulcer treatment consistent with professional standards of practice for Resident #101. The clinical record of Resident #101 was reviewed 1/15/19 through 1/17/19. Resident #101 was admitted to the facility 12/29/18 with diagnoses that included but not limited to	F 686	F 686 1. Resident #101 is currently receiving wound care based on professional standard of practice, MD notified of treatment performed with NNO. 2. Current residents with wound care dressing orders were reviewed. Current nurses performing dressing changes were observed to ensure professional standard of practice was followed while performing cleansing of the wound. Corrections were made as necessary. 3. Current licensed nursing staff were educated regarding professional standard of practice when performing cleansing of a wound. Nursing leadership will complete treatment administration observations for 2 nurses weekly X 4 weeks to ensure	2/19/19

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gangrene, type 2 diabetes mellitus, hypothyroidism, hyperlipidemia, polyneuropathy, gastroesophageal reflux disease, atherosclerotic heart disease, and hypertension.

Resident #101's admission minimum data set (MDS) with an assessment reference date (ARD) of 1/5/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section M Skin Conditions assessed the resident with one unstageable pressure area but covered by slough and/or eschar.

The most recent skin and wound evaluation was completed 1/4/19 and identified Resident #101 to have a pressure ulcer that was unstageable that was present on admission, obscured full thickness skin and tissue loss due to slough and/or eschar, located on the right heel and measured 3.3 centimeters (cm) (length) x 2.4 cm (width).

Resident #101's wound care orders dated 1/17/19 read "Cleanse with NS (normal saline) and apply dry dressing to right heel every day shift for wound care."

The surveyor observed wound care to Resident #101's right heel on 1/17/19 at 11:21 a.m. with licensed practical nurse #2. L.P.N. #2 prepped the over the bed table, washed her hands and applied gloves and proceeded to remove the resident's boot and dressings and discard the soiled dressings in a proper receptacle. The area on Resident #101's right heel area was a little larger than quarter size, was round and was black in color, and looked like black leather. L.P.N. #2 cleaned the pressure area with normal saline applied to a gauze. L.P.N. #2 dabbed the circular

compliance with professional standards of practice. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for one quarter.

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F 686	Continued From page 25 wound multiple times, then folded the gauze and dabbed some more and then folded the gauze and dabbed some more. The wound was not cleaned in a circular manner from the inner part of the wound to the outer. The surveyor interviewed L.P.N. #2 at the completion of wound care about the method used for cleaning the wound. L.P.N. #2 stated she was unaware of wound cleaning guidelines. The surveyor informed the unit manager licensed practical nurse #1 of the above concern on 1/17/19 at 12:10 p.m. The surveyor requested the face sheet, MDS of 1/5/19, current care plan and the facility policy on wound care/dressing changes. L.P.N. #1 stated clean wounds from inner to outer. The surveyor informed the corporate registered nurse #1 of the above concern on 1/17/19 at 12:30 p.m. The surveyor asked corporate registered nurse #1 how wounds should be cleaned. Corporate R.N. #1stated whatever the professional standard was for wound care. The surveyor reviewed the policy provided on 1/17/19 about dressing changes. The policy titled "General Wound Care/Dressing Changes" read in part, "Licensed nurses will follow recognized standards of practice regarding dressing changes, including date and initials on dressing." No further information was provided prior to the exit conference on 1/17/19.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		2/5/19

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F 689	Continued From page 26 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint survey the facility staff failed to ensure an accident free environment ofr 1 of 31 Resident, #111. The findings included: For Resident #111 the facility staff failed to ensure an accident free environment resulting Resident receiving a laceration to leg that required suturing. Resident #11 was admitted to the facility on 11/08/12 and readmitted on 02/22/16. Diagnoses included but not limited to congestive heart failure, hypertension, aphasia, dementia, depression, atrial fibrillation, gastroesophageal reflux disease, and history of trans-ischemic accident. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/19/17 coded the Resident as having both long and short-term memory loss with severely impaired cognitive skills for daily decision making in section C, cognitive patterns. Section G, functional status, coded the Resident as 4/3 in the areas of bed mobility and transfer, which is the equivalent of "total dependence/two person	F 689	Past noncompliance: no plan of correction required.	

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physical assist". This is a quarterly MDS.

Resident #111's CCP (comprehensive care plan) was reviewed and contained care plan for "the Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia". Interventions for this care plan included "BATHING/SHOWERING: The Resident requires full assistance, BED MOBILITY: The Resident requires full assistance, DRESSING: The Resident requires full assistance, TRANSFER: The Resident requires Mechanical Lift Hoyer (2) staff assistance for transfers". The CCP also contained a care plan for "The Resident is at risk for skin tears Created on: 10/07/14 Revision on: 09/27/17". Interventions for this care plan included "use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Created on: 06/30/2015. Revision on: 08/11/2016".

Resident #111's clinical record was reviewed on 01/16/19. It contained a nurse's progress noted dated 12/01/17 which read in part, "12/1/2017 20:45 Change of Condition Note Text: Pt obtained skin tear/laceration to right posterior lower leg when in the shower chair. Pressure was applied, hemostasis achieved, dressing applied. PA (physician's assistant) ...(name omitted) and order to send to ...(name omitted) ED (emergency department) for evaluation. Pt's daughter ...(name omitted) notified by ...(name omitted), LPN (licensed practical nurse). Report called to ...(name omitted) ED".

The Resident's clinical record contained an ER report dated 12/01/17 which read in part, "88-year-old-female presents to the emergency

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department after getting a cognitive nursing facility during a transition for bathing. Patient has a large 'dog-eared' laceration to the right lower extremity....Patient is non-verbal severely demented and unable to communicate what occured. Her daughter is at bedside and states the the patient received a cut while transitioning for bathing no falls, no other injuries" and "Wound Extent: no fascia violation noted, no muscle damage noted, no tendon damage noted and no vascular damage noted...Base of wound likely viable with good vascularization closed with 4 sutures. But the distal part of the wound open but reapproximated and placed occlusive dressing with Xeroform impregnated gauze and a simple Kerlex wrap."

The clinical record also contained an "After Visit Summary" from the ER which read in part, "Call ....(name omitted) in 1 day. Why: should be followed by wound management...".

Resident's clinical record contained progress notes which read in part, "12/5/2017 Wound care clinic at this time with new orders to keep dressing intact until Resident returns to clinic in 1 week for dressing change with...(name omitted). Resident to have leg elevated at all times when in wheelchair....", "12/13/17 Dressing to right leg clean, dry and intact. No swelling or foul odor noted. Sutures removed. New order to cleanse wound with saline, apply hydorfera blue ready to wound, cover with ABD pad, secure with 4" kling, change every other day. If dressing is hard to remove, may use saline to remove hydrofera blue. Apply tubi-grip E from base of toes to below knee, followed by ACE wrap compression. F/U (follow up) in 1 week with ...(name omitted)", and "12/19/17 Cleanse with saline, pat dry, appy

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F 689	Continued From page 29 hydrofera blue, secure with kling, change Monday, Wednesday, Friday. Apply tubigrip from base of toes to below knee. Apply ace wrap from base of toes to beljow knee. Follow up in two weeks". Surveyor requested and was provided with the facility's preliminary investigation which included a written statement from RN (registered nurse) #1 dated 12/02/17, which read in part, "Patient ... (Resident #111) received a skin tear to her right posterior calf on the evening of 12/1/17 caused by a bolt on the foot portion of the reclining showe chair. The skin tear occurred while CNA ... (certified nurse's aide) #3 attemped to replace a soiled lift pad under patient after patient's shower. CNA stated she was alone with patient at the time and han not attempted any transfers because the lift pad was not yet under the patient. CNA stated that the skin tear occured after she flipped the foot rest up and began to reposition patient, and that she immediately called for help when the injury occured....Patient to receive all shower via shower stretcher instead of shower recliner or shower chair with staff education provided....". Surveyor was unable to interview RN #1. The preliminary investigaton also contained a written statement from CNA #3 dated 12/01/17, which read in part, "After I had gave ...(Resident #111) a bath I took her to her room to get her prepared for bed. I lowered the head of the chair to put her lift pad back under her, then when I folded the bottom of the chair back it scraped the back of her leg. When I seen blood, I yelled for ... (RN #1) to come, he came and wrapped her leg up then called the hospital to come get her". Surveyor could not interview CNA #3 due to no longer being employed by facility.	F 689		

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Surveyor spoke with unit manager via telephone on 01/17/19 at approximately 0905. Unit manager stated she was not working at the time Resident obtained skin tear.

Surveyor attempted to contact wound care physican via telephone, but was unable to speak with him.

Surveyor spoke with RNC (regional nurse consultant) #1, who was DON (director of nursing) at the time of Resident #111's injury. RNC #1 stated that the Resident had obtained the skin tear while CNA #3 was attempting to place a clean lift pad under the Resident after her shower. RNC #1 provided the surveyor with a copy of the final investigation conducted while he was DON, in which he stated the Resident's skin tear had "occured whild CNA made decision that more room was needed at bottom so she held legs up and when at same time bringing the foot rest up toward chair scraping Resident's lower leg causing an abrasion". RNC #1 also stated the Resident had fragile skin and history of long term anticoagulant use.

RNC #1 provided the surveyor with a copy of "5 Step Plan-Mechanical Lifts 12/04/2017" which read as follows:

1. Quality assurance that practices two staff members are present when performing a mechanical lift transfer.
2. Current Residents requiring mechanical lifts were reviewed by nursing leadership. Care plans were reviewed to ensure that use of 2 staff persons was identified and is being implemented. Corrections were made immediately as indicated.
3. Current nursing staff were educated on

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F 689	Continued From page 31 procedures for using a mechanical lift with return demonstration. Mechanical lift transfers will be reviewed and observed with new nursing staff during orientation period. SDC (staff development coordinator) or designee will randomly review three lift transfer weekly x 4 to ensure standard procedures are being followed. 4. Process will be reviewed in next quarterly QA (quality assurance). 5. 12/31/17 Throughout the course of the survey, no Residents on the 500 hall were observed to have "broken bones". No Residents were observed being left in the bathroom/on toilet for extended periods. This allegation was discussed with the administrative team during a meeting on 01/17/19 at approximatley 1300. No further information was provided prior to exit. This is a complanit deficiency.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		2/19/19

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F 757	Continued From page 32 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 31 residents were free of unnecessary medications (Resident #70 and Resident #100). The findings included: 1. The facility staff failed to follow the physician orders for administration of sliding scale insulin for Resident #70. Accuchecks were not obtained as ordered for Resident #70. Resident #70 was admitted to the facility 10/25/18 with diagnoses that included but not limited to type 2 diabetes mellitus, chronic obstructive pulmonary disease, insomnia, anxiety, major depressive disorder, hyperlipidemia, hypertension, acute systolic heart failure, dysarthria and anarthria, hypokalemia, atrial fibrillation, and gastroesophageal reflux disease. Resident #70's 5-day readmission minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/26/18 assessed the resident with a BIMS (brief interview for mental status) as 13/15.	F 757	F 757 1. The MD was notified of omitted blood sugars for Residents #70 and #100, NNO given. Residents #70 and #100 are currently receiving sliding scale insulin as ordered by the physician based on blood sugar results 2. Current residents receiving sliding scale insulin were reviewed to ensure accuracy of medication based on blood sugar readings. Corrections were made as necessary. 3. Current licensed nursing staff were educated regarding medication administration to include following physician orders for blood sugar checks and administration of sliding scale insulin. Nursing leadership will audit medication administration records for Residents receiving sliding scale insulin weekly X 4 to ensure accuracy. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for one quarter.	

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The facility had not developed a care-plan for diabetes mellitus.

The December 2018 and January 2019 physician orders read in part "Novolog FlexPen Solution Pen-Injector100 unit/ml (milliliter) (Insulin Aspart) Inject as per sliding scale: if 0-60=0 Notify MD (medical doctor); 61-199-0; 200-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401+Notify MD, subcutaneously before meals and at bedtime for DM (diabetes mellitus)."

The surveyor reviewed the December 2018 and January 2019 electronic medication administration records (eMAR). On 12/1/18 at 0630, the eMAR did not have the results of the blood sugar. The surveyor reviewed the weights and vitals summary record. The weights and vital summary sheet did not include a blood sugar result for 12/1/18 at 0630. The surveyor reviewed the three progress notes for 12/1/18. The notes did not reveal the results of a blood sugar for 12/1/18 at 6:30 a.m.

The surveyor informed the unit manager licensed practical nurse #1of the above concern on 1/17/19 at 1:32 p.m. L.P.N. #1 reviewed and stated she was unable to locate the blood sugar results. L.P.N. #1 stated she would call the nurse who worked that night. L.P.N. #1 stated some nurses record blood sugar and vital signs in their own notebook.

The surveyor spoke with licensed practical nurse #1 on 1/17/19 at 2:25 p.m. LPN #1 stated she had called the nurse but had yet to hear back from her.

The surveyor informed the corporate registered

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nurse #1 on 1/17/19 at 2:30 p.m. of the above blood sugar monitoring not obtained on 12/1/18 at 0630.

No further information was provided prior to the exit conference on 1/17/19.

2. The facility staff failed to follow the physician orders for administration of sliding scale insulin for Resident #100. Accuchecks were not obtained as ordered for Resident #100.

Resident #100 was admitted to the facility 1/1/19 with diagnoses that included but not limited to type 2 diabetes mellitus, gastroesophageal reflux disease, hypertension, benign prostatic hyperplasia, gout, and thoracic, thoracolumbar and lumbosacral intervertebral disc disorder.

An admission minimum data set (MDS) had not been completed.

Resident #100's baseline care plan created on 1/1/19 identified a focus area for diabetes mellitus. Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.

Resident #100's January 2019 physician orders included the following order for Novolog sliding scale insulin and accuchecks: Novolog FlexPen Solution Pen-Injector 100 unit/ml (milliliter) (Insulin Aspart) Inject as per sliding scale: if 0-59=0 Notify MD (medical doctor); 60-139=0; 140-199=2; 200-249=4; 250-299=6; 300-349=8; 350-999=10, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus Without Complication.

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F 757	Continued From page 35 The January 2019 electronic medication administration record (eMAR) was reviewed. On 1/8/19 at 0600, the blood sugar was not obtained. The surveyor reviewed the weights and vital summary sheet and the 1/8/19 progress notes. There was no evidence the blood sugar had been obtained. The surveyor interviewed the unit manager licensed practical nurse #1 on 1/17/19 at 12:46 p.m. L.P.N. #1 stated she would call the nurse and speak with her. She stated some nurses keep a paper record on their own. L.P.N. #1 was asked if that was part of the clinical record. L.P.N. #1 stated no. The surveyor spoke with licensed practical nurse #1 on 1/17/19 at 2:25 p.m. LPN #1 stated she had called the nurse but had yet to hear back from her. The surveyor informed the corporate registered nurse #1 on 1/17/19 at 2:30 p.m. of the above blood sugar monitoring not obtained on 1/8/19 at 0600. No further information was provided prior to the exit conference on 1/17/19.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		2/19/19

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F 761	Continued From page 36 §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, the facility staff failed to dispose expired medications in 1 of 6 medication carts. The findings included: The facility staff failed to dispose of expired regular strength enteric coated aspirin in medication cart on 200 hallway. During a medication administration observation the surveyor checked the medication cart of the 200 hallway on 01/16/19 at approximately 8:40 am. The cart contained an opened bottle of house stock regular strength enteric coated aspirin with an expiration date of "11/17" (November 2017). The surveyor showed the expiration date to LPN (licensed practical nurse)	F 761	F761 1. Expired aspirin was discarded during the survey. 2. Medication carts were observed to determine the presence of expired medications. Corrections were made as necessary. 3. Current licensed nursing staff were educated regarding medication storage to include expiration dates. Nurses will store medications according to pharmacy and/or manufacturer guidelines and will discard expired medications. Nursing leadership will observe medication carts from each unit weekly X4 to ensure medications are stored properly based on expiration dates. Any issues will be addressed immediately at the time of identification.	

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F 761	Continued From page 37 #1. The surveyor observed LPN #1 dispose of expired aspirin immediately in sharps container. The administrative team was notified of the above findings during an end of day meeting on 01/16/19 at approximately 5:10 pm. On 01/17/19 the ADON (assistant director of nursing) provided the surveyor with a copy of a policy/procedure titled "Storage and Expiration of Medications ..." page 2 of this document read under Procedure: #5 of policy "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications ..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 761	4. Process will be reviewed in QA committee for one quarter.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident	F 803		2/19/19

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F 803

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groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to honor food choices for 2 of 31 residents (Resident #107 and Resident #197).

The findings included:

1. The facility staff failed to honor food choices made by Resident #107.

Resident #107 was admitted to the facility 12/30/18 with diagnoses that included fall with a fractured left hip, hypertension, anemia, and chronic kidney disease.

Resident #107's admission minimum data set (MDS) with an assessment reference date (ARD) of 1/5/19 assessed the resident with a brief interview for mental status (BIMS) as 14/15. Current comprehensive care-plan created on 12/30/18 and revised on 1/16/19 identified the resident to be at risk for nutrition. Interventions: provide diet as ordered. Monitor intake and record each meal. Offer substitutes when intake less than 50%.

F 803

F 803
1. Residents #107 and #197 received the food items that were missing from trays after surveyor observation. Residents #107 and #197 are currently receiving a diet that honors food choices.
2. Current residents were reviewed to ensure that choices are being honored. Corrections were made as necessary.
3. Dietary manager, Registered Dietician, and current nursing staff were educated regarding select menus that honor choice and preference. A sample of 10% of current Residents will be interviewed regarding choices and preferences including an observation of trays weekly X4. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in quarterly QA meeting.

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Resident #107's January 2019 physician orders included dietary orders for regular diet.

The surveyor interviewed Resident #107 on 1/16/19 at 11:51 a.m. When asked about the food, the resident said the food was "so-so" and stated she didn't get any syrup with her pancakes this morning.

The surveyor observed the resident at lunchtime on 1/16/19. The tray ticket was marked for the alternates-soft beef taco, scalloped potatoes, pinto beans, wheat roll, and apple brown betty.

Resident #107 did not receive the pinto beans that were circled on the tray ticket and received lettuce that she had not requested.

The surveyor spoke with certified nursing assistant #1 on 1/16/19 at 12:15p.m. C.N.A. #1 went to the kitchen and got her requested food item.

The surveyor informed the administrative staff of the above concern on 1/16/19 at 5:09 p.m.

The surveyor reviewed the facility policy titled "Meal Delivery" on 1/17/19. The policy read in part "3. The nursing department shall be responsible for the delivery of meals to the patient with the following requirements: Nursing will assist the patient with tray set up as necessary (open milk and juice, open condiments, cut meat, butter bread, etc.). The tray identifier/menu ticket or alternate method of identification as appropriate shall remain with the place setting during meal times. 4. Nursing staff will offer alternates to any patient who does not eat at least

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F 803	Continued From page 40	F 803		

50% of their meals or who refuses a food. Nursing will notify the dining services department of a patient's desire for an alternate and deliver the alternate to the patient."

No further information was provided prior to the exit conference on 1/17/19.

2. The facility staff failed to honor food choices made by Resident #197.

Resident #197 was admitted to the facility 1/8/19 with diagnoses that included but not limited to type 2 diabetes mellitus, hypertension, short Achilles tendon repair, hyperlipidemia, and difficulty in walking.

An admission minimum data set (MDS) had not been completed.

Resident #197's baseline care plan created 1/8/19 identified a focus area for diabetes mellitus. Interventions: offer substitutes for foods not eaten.

Resident #197's January 2019 physician orders included a dietary order for a diabetic diet-level 7.

The surveyor interviewed Resident #197 on 1/16/19 and stated the food was good. The surveyor observed the resident on 1/17/19 at breakfast. Resident #197 stated he didn't get the oatmeal he had requested the day before. He stated he can choose what he wanted for meals and wanted oatmeal for breakfast. A review of the tray ticket indicated oatmeal had been circled but not delivered. Resident #197's tray did include the other choices made-scrambled eggs, bacon, and apple juice.

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F 803	Continued From page 41 The surveyor informed certified nursing assistant #2 of Resident #197's tray missing oatmeal. C.N.A. #2 stated he would get the oatmeal from the kitchen. The surveyor informed the unit manager licensed practical nurse #1 and the registered dietician on 1/17/19 at 2:04 p.m. The surveyor informed the corporate registered nurse #1 of the above concern on 1/17/19 at 2:10 p.m. The surveyor reviewed the facility policy titled "Meal Delivery" on 1/17/19. The policy read in part "3. The nursing department shall be responsible for the delivery of meals to the patient with the following requirements: Nursing will assist the patient with tray set up as necessary (open milk and juice, open condiments, cut meat, butter bread, etc.). The tray identifier/menu ticket or alternate method of identification as appropriate shall remain with the place setting during meal times. 4. Nursing staff will offer alternates to any patient who does not eat at least 50% of their meals or who refuses a food. Nursing will notify the dining services department of a patient's desire for an alternate and deliver the alternate to the patient." No further information was provided prior to the exit conference on 1/17/19.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		2/19/19

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F 812	Continued From page 42 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store, label, date, and remove expired food items in the facility kitchen. The findings included: The facility staff failed to date food items when opened and failed to remove food items that were past their "use by date". The surveyor toured the kitchen with the dining services manager on 1/15/19 beginning around 12:05 p.m. The surveyor observed the spices on the shelf. The dietary services manager stated the spices have a sticker on them when they arrive in the kitchen and he stated all the spices were removed after 1 year. He stated the shelf life for the spices was approximately 6 months. On the	F 812	F 812 1. Expired spices, soy sauce, and buttermilk were discarded during the survey. 2. A kitchen inspection was completed to identify any further evidence of expired spices, sauces and buttermilk and appropriate labeling. Corrections were made as necessary. 3. Current dietary staff were educated regarding food safety requirements to include labeling of opened items and expired items. Kitchen audits will be conducted by dietary consultant weekly X4 weeks to ensure compliance. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in quarterly QA meeting.	

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F 812	Continued From page 43	F 812		

shelf, the surveyor and the dietary services manager observed a 6-ounce bottle of Thyme leaves dated 8/23/17. The dietary services manager stated "it was a little past the use by date" and removed the bottle from the shelf. The dietary services manager stated thyme was a little strong for the residents and the spice was mainly used for catering. On the shelf was also a bottle of Rotisserie Chicken seasoning 24-ounces. There was not a date when opened or a sticker when the spice first arrived.

The surveyor and the dietary services manager checked the walk-in refrigerator. In the refrigerator was a gallon of soy sauce that did not have a date when opened. The date stamped on the bottle was 11/29/17. The dietary services manager removed the bottle of soy sauce. Also, in the refrigerator was a quart of buttermilk. The "use-by-date" was 1/9/18. The staff had not dated the buttermilk when opened.

The surveyor spoke with the registered dietician and the dietary services manager about the expired food items in the kitchen and requested the facility policy on labeling and dating food items.

The surveyor reviewed the facility policy titled "Refrigerated and Frozen Foods" on 1/15/19. The policy read in part "2. All refrigerated and frozen food containers will be labeled, indicating the name of the product and the use-by-date. 5. All refrigerated and frozen foods will be used or discarded by the use-by date indicated on the manufacturer's label. Frozen foods will be used or discarded within six (6) months of receipt if no manufacturer use-by-date is listed on the package. For refrigerated foods, if no

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F 812	Continued From page 44 manufacturer use-by-date is listed on the package, the refrigerated food storage schedule will be used." The surveyor informed the administrative staff of the concerns in the facility kitchen on 1/15/19 at 3:49 p.m. No further information was provided prior to the exit on 1/17/19.	F 812		
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; (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	F 842		2/19/19

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F 842	Continued From page 45 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 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.	F 842		

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F 842	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 2 of 31 Residents. #55 and Resident #300. The findings included: 1. For Resident #55 the facility staff failed to ensure a complete Virginia Department of Health DDNR (durable do not resuscitate) form was included in the clinical record. Resident #55 was admitted to the facility on 05/23/14 and readmitted on 12/13/18. Diagnoses included but not limited to congestive heart failure, hypertension, peripheral vascular disease, pneumonia, septicemia, diabetes mellitus, aphasia, dementia, hemiplegia, asthma, and respiratory failure. Section C (cognitive patterns) of the most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/20/18 coded the Resident as having both long and short term memory problems with severely impaired cognitive skills for daily decision making. Resident #55's clinical record was reviewed on 01/15/18. It contained a Virginia Department of Health DDNR form, which read as follows: "I further certify (must check 1 or 2): [] 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment (Signature of patient is required)	F 842	F 842 1. Resident #55s DDNR form was completed and included in the clinical record. Resident #300s code status was verified and accurate documentation placed in the clinical record. 2. Current residents with DDNR orders were reviewed to ensure accurate documentation. Corrections were made as necessary. 3. Current licensed nursing staff were educated regarding obtaining DDNR orders at the time of admission and/or readmission and accurate completion of DDNR forms. Medical Records will review a 10% sample of DDNR orders weekly X 4 to ensure accuracy. Any issues will be corrected immediately at the time of identification. 4. Process will be reviewed in QA committee for one quarter.	

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[] 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequence of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:
[] A. While capable of making an informed deacon, the patient has executed a written advanced directive which direct that life-prolonging procedures be withheld or withdrawn.
[] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of Person Authorized to Consent on jthe Patient's Behalf is required).
[] C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)"

Sections I and II of the DDNR had not been checked as directed.

Surveyor informed the RNC (regions nurse consultant) of the incomplete DDNR on 01/15/19 at approximately 1630. RNC provided the surveyor with a copy of a DDNR form in which section I was complete, but section II was incomplete on 01/15/19 at approximately 1645.

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On 01/16/19 at approximately 0745, the DON (director of nursing) provided the surveyor with a copy of the DDNR form in which both sections I and II were complete. DON stated the completed DDNR form had been located in the Resident's thinned chart.

The concern of the correct DDNR not being located in the Resident's clinical record was discussed with the administrative team during a meeting on 01/16/19 at approximately 1710.

No further information was provided prior to exit.

2. For Resident #300, the facility failed to sustain an accurate clinical record regarding Resident #300's code status.

The clinical record review revealed that Resident #300 had been admitted to the facility on 01/09/19. Diagnoses included, but were not limited to, major depressive disorder, diabetes, chronic obstructive pulmonary disease, and acute respiratory failure.

Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/09/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

On 01/16/19 at 2:50pm the surveyor reviewed Resident #300's clinical record. The Resident's clinical record included a DDNR (durable do not resuscitate) order form dated 04/18/16 from the Virginia Department of Health. Resident #300 was listed as a full code in electronic medical record.

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Resident #300's physician's orders contained an order for "FULL CODE" dated 01/09/19.

During an observation on 01/16/19 at 2:39pm, the surveyor asked Resident #300 if she had a living will. Resident #300 verbalized she does not want to be resuscitated and she made that decision years ago.

The administrative team was made aware of the above findings on 01/16/19 at 5:10pm at the end of day meeting.

The DON (director of nursing) voiced that Resident #300 should be coded as a DNR (do not resuscitate) in the clinical record.

No further information regarding this issue was provided to the survey team prior to the exit conference.