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	495151	A. BUILDING ______ B. WING ______	C 02/26/2019

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CURIS AT LYNCHBURG NURSING & REHABILITATION CENTER	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/24/19 through 2/26/19. The facility's Emergency Preparedness Plan was reviewed and found to be 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 2/24/19 through 2/26/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 120 bed facility was 106 at the time of the survey. The survey sample consisted of twenty-six current residents and five 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		3/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/15/2019

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 staff interview and facility document review, the facility staff failed to treat one of 31 residents in the survey sample with respect and dignity. The facility administrator yelled and talked over Resident #455 during a conversation regarding the patient pay. The findings include: Resident #455 was admitted to the facility on 08/08/2018 with diagnoses that included: muscle weakness, end stage renal disease requiring	F 550	Past noncompliance: no plan of correction required.	

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dialysis, fever, hypertension, unspecified abnormalities of gait and mobility, atrial fibrillation (AFIB) and systemic inflammatory response syndrome (SIRS). The minimum data set dated 08/14/18 assessed Resident #455 as cognitive intact for daily decision making with a score of 14.

A facility reported incident (FRI) form dated 09/20/18 documented the following, "Resident reported that while the Administrator was speaking along with the S.S. (social worker) and B.O.M. (business office manager) that the Administrator was condescending rude and he felt verbally abused, that she spoke in an angry manner, and was disrespectful."

The facility's investigation of this incident dated 9/24/18 documented two staff interviews from staff who were present during the incident on 9/20/18:

[Name of Social Worker] - "Last week... [Name of Administrator], [Name of Business Office Manager], and I went to talk to [Resident #455] about not paying for his stay. The resident said he was going to report the incident to APS (adult protective services). [Name of Administrator] was yelling, 'You need to pay us.' [Name of DON] said she could hear it in her office with the door closed. The resident said, 'you don't speak to me that way.' [Name of Administrator] said 'as an attorney, I know the law and what you're telling us won't hold up in court.' [Name of Business Office Manager] tried to interject that his (Resident #455) moving from Medicare to Medicaid, he needed to turn over his money except the $40.00. The resident still refused. [Name of Administrator] talked loudly and partially over him. [Name of Administrator] left the room. The

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resident asked [Name of Social Worker] why she let [Name of Administrator] talk to him that way..."

[Name of Business Office Manager] - "We went to talk to him (Resident #455) about payment, the patient pay. [Name of Administrator] and the resident were both talking loudly and trying to talk over each other. The resident said no one told him he was going to have to pay and that he was invited to the facility. The resident would get loud and [Name of Administrator] would get loud back. [Name of Administrator] told the resident he had a room here and would have to pay...They (the resident and [Name of Administrator]) yelled at each other across the room and then she (the administrator) left..."

The facility's investigation of this incident dated 9/24/18 documented the following interview with Resident #455:

[Resident #455] - "...On the day in question, [Name of Administrator], [Name of Business Office Manager], and [Name of Social Worker] came to talk to him about his outstanding bill. He told them he didn't know what they were talking about. [Resident #455] said [Name of Administrator] said, 'you're going to pay. You have money in your account.' He said [Name of Administrator] tone was disrespectful and condescending...They yelled back and forth. [Name of Administrator] walked out. The resident said he asked [Name of social worker] why did she let [Name of Administrator] talk to him like that. The resident said [Name of Administrator] came back and told her (social worker) to get out his room."

The facility's follow-up investigation letter to the

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State Agency documented the following:

"[Name of Resident #455], BIMs of 15, reported that [Name of Administrator], spoke to him in a condescending voice, was rude, angry and disrespectful when she was speaking with him about paying his outstanding bill to the facility. [Name of Administrator] was suspended immediately and sent home. Interviews were done with Social Worker [name] and Business office manager, [name] who were present during the conversation... Staff were in-serviced on the abuse policy as well as receiving a post-test. [Name of Administrator] was given sensitivity training and abuse training by [Name], Director of Operations at [name of company]."

"MD (medical director), APS (adult protective services), DHP (department of health professionals) were notified."

"In conclusion after a through investigation the facility can not substantiate the allegation of verbal abuse to [Resident #455] by [Name of Administrator]."

On 02/26/19 at 11:08 a.m., the social worker (OS #2), who witnessed the incident on 9/20/18 was interviewed. OS #2 stated the incident was in regards to Resident #455 transitioning to long-term care and his patient pay. OS #2 stated the business office manager, the facility administrator, and herself, were all involved in the conversation due to Resident #455 becoming increaslingly agitated during his stay at the facility. OS #2 stated during the discussion of the patient pay with Resident #455, he became loud and cursing, talking over the business office manager and administrator. OS #2 stated the facility

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F 550	Continued From page 5 administrator became loud and started talking over the resident to get her point across. OS #2 stated "they (Resident #455 and the administrator) both yelled back and forth at each other. Resident #455 made the statement that he felt sorry for her (the administrator's) husband and the administrator yelled to the resident 'my husband is deceased' and walked out of the room." On 02/26/19 at 12:11 p.m., the business office manager (OS #4) who witnessed the incident on 9/20/18 was interviewed. OS #4 stated while in the room discussing the patient pay with Resident #455, he begin yelling and cursing at her and the administrator. OS #4 stated the administrator kept speaking overtop of Resident #455 to get out her point about the importance of his patient pay. OS #4 stated they (Resident #455 and the administrator) were both loud, going back and forth. OS #4 stated she and the social worker tried to talk with Resident #455, but he would not listen. OS #4 stated she remembered he (Resident #455) told the administrator he felt sorry for her husband. OS #4 said the administrator yelled at him (Resident #455) and said her husband was deceased and walked out of the room. The Interim Director of Nursing who submitted the follow-up investigation letter was no longer employed by the facility and not available for interview. The facility administrator who was involved in the incident was no longer employed by the agency and was not available for interview. Resident #455 was discharged from the facility on 10/9/18. There was no contact information available for the resident, therefore he was not contacted for an interview.	F 550		

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F 550	Continued From page 6 Resident #455's clinical record was reviewed and there was no information documented regarding this incident. Resident #455's plan of care was reviewed. A focus area created on 08/17/2018 documented the following: [Resident #455] has a psychosocial well-being problem adjusting to a new facility with new caregivers r/t (related to) Recent Admission." Interventions documented "Allow [Resident #455] time to answer questions and to verbalize feelings, perceptions and fears; Assist/encourage/support [Resident #455] to set realistic goals; [Resident #455] needs assistance/encouragement/support to identify problems that cannot be controlled; When conflict arises, remove resident to a calm safe environment and allow to vent/share feelings." These findings were reviewed with the administrator, director of nursing, and regional consultants during a meeting on 02/26/19 at 2:07 p.m. No further information was received by the survey team prior to the exit conference on 02/26/19 at 3:45 p.m. This was a complaint deficiency.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		3/18/19

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F 584	Continued From page 7 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a safe, clean and homelike environment on two of four living units.	F 584	1. The damaged access cover on Brookside which created a trip hazard was fixed on 02/26/2019. The damaged	

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F 584	Continued From page 8 On the Brookside unit, there was a damaged access cover in the hallway creating a trip hazard and a damaged over-bed table in room 45. On the Pondside unit, water was leaking into the floor around the ice machine with resulting floor damage. The louvered air return panel on the Pondside unit was dirty with heavy lint accumulation. The findings include: On 2/24/19 at 3:45 p.m., a damaged access cover in the center of the hallway on the Brookside unit was observed. The circular panel was bent and partially raised from the floor creating a trip hazard. Residents and staff members were observed walking in the hallway in the area of this bent cover. Also on this unit, an over-bed table in room 45 was in disrepair. The corners/edges of the tables extended beyond the plastic trim with rough particle board visible. On 2/25/19 at 10:40 a.m., a damaged section of flooring was observed on the Pondside unit. This flooring near the ice maker was separated and torn resulting in a trip hazard. Water was also in the floor under the ice maker. The large louvered air return panel on the wall near the ice maker was dirty with accumulated lint/debris. On 2/26/19 at 8:00 a.m., the facility's maintenance director was shown the above items and interviewed about the needed repairs. The maintenance director stated he was aware of the floor damage near the ice maker but he did not have matching floor materials to repair the area. When asked how long the floor had been damaged, the maintenance director stated, "I would say weeks." The maintenance director	F 584	over-bed table in room 45 was replaced. The louvered air return panel on the Pondside unit was cleaned. 2. All over-bed tables in the building were inspected for damage. All sewage drains were checked for any ability to cause a trip hazard. The one louvered air return panel on the Pondside unit was cleaned. 3. The facility will purchase new over bed tables monthly until all replaced and new. The Maintenance Director will monitor the function of all overbed tables weekly for 4 weeks then monthly for 3 months. The Maintenance Director will check covers for all sewage drains weekly for 4 weeks then monthly for 3 months to determine whether any are damaged. The Maintenance Director will clean louvered air return for no dust or dirt accumulation weekly for 4 weeks then monthly for 3 months. 5. The Administrator will follow record keeping and review in QAPI monthly.	

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F 584	Continued From page 9 stated he was not sure if the ice maker was leaking or if the water in the floor was from spilled ice. The maintenance director stated his department was responsible for cleaning the louvered air return panel. The maintenance director stated the circular covers along the hallway floors were access points to the sewage system. The maintenance director stated the access cover on the Brookside unit might have been damaged by the floor scrubber. The maintenance director stated he had bed tables for the facility on order but currently did not have a replacement for the damaged table in room 45. The maintenance director stated staff members were supposed to submit work orders for any needed repairs. The maintenance director stated there were no previous work orders submitted concerning the above items in disrepair. On 2/26/19 at 11:45 a.m., the administrator stated they had recognized that bed tables were in disrepair and were working on getting new tables. These findings were reviewed with the administrator and director of nursing during a meeting on 2/25/19 at 5:15 p.m.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		3/15/19

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F 607	Continued From page 10 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement written policies and procedures for the prevention of abuse, neglect and exploitation for one of 31 residents in the survey sample, Resident #42. The facility staff failed to investigate an injury of unknown origin, involving Resident #42. The resident was found with a "knot" and "small laceration" over his left eye, in addition to a broken front tooth. The facility failed to investigate, focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment occurred, the extent, and cause; and failed to provide a complete and thorough documentation of the investigation. Findings include: Resident #42 was admitted to the facility on 01/02/19. Diagnoses for Resident #42 included, but were not limited to: syncope/collapse, high blood pressure, weakness, diabetes mellitus, seizures, history of chest pain, and major depressive disorder. The most current MDS (minimum data set) was an assessment with an ARD (assessment reference date) of 01/09/19. The resident was assessed with a cognitive score of "6", indicating the resident had moderate impairment in daily decision making skills. The resident was documented as requiring extensive assistance of	F 607	1. On 02/26/2019 facility investigated Resident # 42 for the allegation of injury of unknown origin according to facility written policies and procedures. 2. The facility conducted skin assessments on all patients admitted to the facility on 02/26/2019 to identify and investigate injury of unknown origin found. 3. (A) The Administrator and DNS will be educated of the following procedure for investigating injuries of unknown origin. (B) The facility will review all injuries of unknown origin (IUO) to determine whether a thorough investigation was conducted and report to the State agency as indicated by findings ongoing. 4. The Administrator will follow record keeping and review in QA monthly.	

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at least one person for bed mobility, transfers, walking in room and corridor, dressing, toileting, and personal hygiene. The resident triggered in the CAAS (care area assessment summary) section of this MDS for, but not limited to: cognition, ADL's (activities of daily living), urinary, behaviors and falls. Section L Oral/Dental Status was reviewed on this MDS and documented, "none of the above" for any type of dental/oral issues or concerns.

A nursing note dated 01/30/19 documented that the resident's family was in the facility visiting and had a concern regarding Resident #42 having a knot with a small laceration above his left eye and having a front tooth broken.

No other documentation was found regarding the above in the resident's clinical record.

The resident's physician's orders were reviewed and included an order for weekly skin assessments. The residents skin assessments were reviewed and did not evidence the resident had any skin impairments and/or concerns. A skin assessment dated 01/31/19 (the day after the concern) was completed by the DON (director of nursing) that documented the resident had no new skin areas/impairments and that skin was intact.

A nursing note was documented by LPN (Licensed Practical Nurse) # 2 on 01/31/19, that Resident #42 had no new skin issues/concerns noted.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...requires assistance with transfers and mobility, which

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F 607	Continued From page 12 could contribute to risk of falls...call bell in reach...encourage..to call for assist..." On 02/25/19 at 4:10 PM, the DON was interviewed regarding where information would be documented for a resident who had a fall (with or without injury) and/or a resident that sustained an injury/trauma of unknown origin. The DON stated that information regarding falls and/or incidents could be found in the risk management section of the electronic medical record and stated that this just started. The DON stated that in January, information was kept in a large binder. The DON was asked to assist with looking for any information and/or documentation for Resident #42 regarding a fall and/or injury of known or unknown origin. The DON looked in the computer system and stated that there was nothing for this resident in the risk management section, but would go get the binder to check it. On 02/25/19 at 4:17 PM, the DON presented the binder and stated that she did not see any information regarding Resident #42. The binder was reviewed and no information was found pertaining to Resident #42. The DON was interviewed regarding the nursing note on 01/30/19 for Resident #42. The DON stated, "that should have been investigated." The DON stated that she remembered something about this and had asked the resident a couple of days later what happened and the resident told her that he hit his head on the night stand. The DON stated that conversation happened "after" and went on to say, "it [injury] was healing" when she had asked the resident what happened. The DON stated that conversation either took place that day or a few days later. The DON stated that the resident told her that he hit his head on the night	F 607		

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CURIS AT LYNCHBURG NURSING & REHABILITATION CENTER	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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stand and that she [the DON] moved his night stand out away from the bed. The DON stated that she didn't understand why the nurse who wrote the note on 01/30/19 about the injury didn't complete an incident report or investigate.

On 02/25/19 at 5:45 PM, the DON, administrator, and nurse consultant were made aware of the above concerns with this resident. The POS (physician order set) and care plan for this resident was requested, along with a policy on falls/injuries of unknown origin and investigation.

On 02/26/19 at 9:16 AM, a policy was presented on Fall Response and Management.

The policy documented, "...Unwitnessed fall/resident injury...evaluate injury...determine extent of the resident's injuries...change in level of consciousness...pain...location and severity...look for lacerations, abrasions, and obvious deformities...provide first aid for minor injuries...notify the doctor...determine whether the resident experienced head trauma...monitor neurological assessments per physician's orders or every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 2 hours or until condition stabilizes, if resident has hit head...investigate the cause of the fall after emergency care has been given...notify physician and family...complete the post fall investigation and event report...revise plan of care...document in the medical record..." None of the above interventions or actions were found for this resident.

On 02/26/19 at 9:37 AM, Resident #42 was interviewed and was asked if he remembered having a a fall or an injury about a month ago

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where he hurt his eye/head area. The resident was asked if her remembered having a fall or an injury where he hurt his eye, leaving a knot and a cut. The resident stated, yes. The resident was asked if he could talk about what happend. The resident stated that he just fell and hit it. The resident was asked where he fell, the resident stated that he fell in his room. The resident stated that he thought he hit the "bed post", but wasn't for sure. The resident was asked if he broke or chipped a tooth at that time and the resident stated, yes. The resident stated that he did report this to someone and thought it was nurse, but could not remember who it was.

On 02/26/19 at 9:44 AM, the administrator stated that he wanted to discuss the information regarding Resident #42 and stated that an investigation was completed under the previous administration, but they (staff) couldn't find it and went on to say that "we" (current administration) went back yesterday and talked to the nurses and CNAs (certified nursing assistants). The administrator was asked to bring any information regarding an investigation. The administrator was made aware that investigation for this resident was requested yesterday and was informed by the DON, that an investigation was not completed on this resident regarding this incident.

On 02/26/19 at 9:59 AM, the administrator, corporate nurse, and the DON (director of nursing) were interviewed with the survey team. The administrator stated, "We could not find the investigation that was done while we had our previous DON, but we found information in the computer indicating that one was done." The administrator was asked where the information

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F 607	Continued From page 15 was. The administrator stated that it is in the documentation presented. The information presented was reviewed and did not reveal that an investigation had been completed. The DON stated that there was a physician's progress note regarding this incident. The physician's progress note documented, "...DOS (date of service) 1/30/2019...63 years...male...assessed with staff due to concerns about the sudden purple discoloration of his mouth...no history of falls reported...Ears/Nose/Mouth/Throat...staff concerns of purple discoloration of his mouth and teeth...mucosa including tongue, was covered by purple discoloration...the teeth were decayed and some broken...kept under observation..completely asymptomatic...look out for any nausea, vomiting...signed by physician 02/26/2019 7:58 AM." The DON, administrator and corporate nurse were made aware that the physician's progress note did address the concern, which was a knot with small laceration to the eye and a broken front tooth per the nursing note of family concerns. The facility staff were also made aware that this incident occurred on 01/30/19 and the physician just made a note today, 02/26/19. No further information and/or documentation was presented prior to the exit conference on 02/26/19 at 3:34 PM to evidence that the facility staff completed and investigation of an injury of unknown origin for Resident #42.	F 607		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		3/20/19

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be 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

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F 623	Continued From page 17 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related 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	F 623		

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F 623	Continued From page 18 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide written notification of a facility initiated hospital transfer for one of 31 residents in the survey sample: Residents #77. Resident #77 was discharged to hospital and the facility did not notify the Ombudsman or the responsible party (RP) in writing. The Findings Include: Resident #77 was admitted to the facility on 8/9/11 with the most recent readmission on 2/20/19. Diagnoses for Resident #77 included: Depression, end stage renal disease, diabetes. Resident #77 is his own responsible person (RP). The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 2/1/19. Resident #77 was assessed as being cognitively intact with a score of 15 of 15.	F 623	1. Resident #77's notice of discharge was sent to the LTC Ombudsman on 02/27/2019. 2. The facility identified residents affected by deficient practice of notice of discharges sent to the LTC Ombudsman and residents from January 2019 to present have had notices of discharges sent to the LTC Ombudsman and resident representative. 3. (A) Nurses and SW will be educated on providing notices to residents or resident representative of discharge and documenting it in EMR. (B) The SW will be educated on providing notifications to LTC Ombudsman of all discharges including hospitalizations. (C) The ED and SW will review discharges daily in morning clinical meeting to verify residents discharges on evening, night shifts and weekends were	

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F 623	Continued From page 19 On 2/25/19 Resident #77's medical record (via hospital discharge summaries) indicated that Resident #77 was admitted to the hospital on 1/17/19 with a primary diagnoses of infection Staphylococcus aureus bacteremia, and returned back to the facility on 1/25/19; admitted to the hospital on 2/8/19 with primary diagnoses of Thrombosis of jugular vein, returned back to the facility on 2/13/19; admitted back to the hospital again on 2/16/19 with primary diagnoses of agitation with behaviors, and returned back to the facility on 2/20/19. Resident #77's progress notes were reviewed: A progress note dated 1/16/19 evidenced that the facility initiated the transfer to the hospital due to a physician's order secondary to possibility of dehydration and abnormal elevated temperature. A progress note dated 2/7/19 evidenced that the facility initiated the transfer to the hospital due to a CT (computer tomography) scan that showed abnormality. A progress note dated 2/16/19 evidenced that the facility initiated the transfer to the hospital for evaluation due to behaviors exhibited by Resident #77. On 02/26/19 at 8:09 AM, the social worker (other staff, OS #2) was interviewed concerning written notification to the Ombudsman office for Resident #77, describing the reasons for the above mentioned discharges. OS #2 verbalized she did not provide written notification to Ombudsman or representative of discharge to hospital and only provides information to the Ombudsman's office when a resident discharges to the community and	F 623	given written notices of bed hold policy. (D) The SW maintain record showing notifications to LTC Ombudsman and resident/resident representative of discharge. 4. The Administrator will follow record keeping and review monthly QAPI.	

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F 623	Continued From page 20 was unaware that notification needed to be sent when a resident discharges to the hospital. On 02/26/19 at 9:02 AM, the admissions director (OS #3) was also interviewed concerning written notification to the Ombudsman office and representative. OS #3 confirmed that the social worker did all discharge notifications. On 02/26/19 at 2:09 PM, the administrator and director of nursing were informed of the above finding. The administrator verbalized that the social worker does send the Ombudsman's office notification when a Resident is discharged, but not when a Resident is discharged to the hospital with intent to return to the facility. No other information was presented prior to exit conference on 2/26/19.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		3/13/19

F 657 Continued From page 21

medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 31 residents in the survey sample, Resident #77 and #46.

1. Resident #77's care plan was not revised to reflect discontinuation of dialysis and shunt.

2. Resident #46's plan of care was not revised to include problems, goals and/or interventions regarding chronic nausea.

The Findings Include:

1. Resident #77 was admitted to the facility on 8/9/11 with the most current readmission on 2/20/19. Diagnoses for Resident #77 included: Depression, end stage renal disease, diabetes. The current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 2/1/19. Resident #77 was assessed as being cognitively intact with a score of 15 of 15.

On 02/24/19 at 4:30 PM, Resident #77 was

F 657

1. (A) Resident #77's care plan was immediately reviewed and revised to reflect the discontinuation of dialysis treatment.
(B) Resident # 46's care plan was reviewed and revised to reflect focus, goals and interventions r/t chronic nausea.

2. (A) An audit of care plans of all dialysis residents was completed to assure that the dialysis status was correct and appropriately addressed in the care plan.
(B) An audit by the MDS personnel of all current residents receiving medication for nausea and or vomiting was conducted and corrections/revisions have been completed on the care plan as appropriate.

3. (A/B) The MDS department has been in-serviced by the nurse consultant on the updating/revising of dialysis care plans and residents displaying signs / symptoms of nausea and /or vomiting by reviewing the nursing 24-hour summary and new

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F 657	Continued From page 22 interviewed. When asked of any concerns regarding dialysis, Resident #77 verbalized that he no longer receives dialysis and it was his choice not to receive dialysis anymore. On 2/25/19 Resident #77's medical record was reviewed. According to a discharge hospital summary dated 2/20/19, Resident #77 stated that he no longer wished to receive dialysis and understood the complications. During the hospital stay Resident #77's dialysis access port was removed and Resident #77 returned back to the facility. Resident #77's care plan was then reviewed and evidenced that a care plan dated 1/29/19 was still in place for dialysis and care of dialysis access port. On 02/25/19 at 4:59 PM, the director of nursing (DON) was interviewed concerning Resident #77 refusing dialysis with regards to the care plan. The DON verbalized that after coming back from hospital the last time, Resident #77 made the decision not to do dialysis anymore and the dialysis shunt was removed at the hospital. The DON was asked about updating care plan to reflect discontinuation of dialysis. The DON reviewed the care plan and verbalized that the care plan should have been updated when Resident #77 came back from the the hospital. No other information was provided prior to exit conference on 2/26/19. 2. Resident #46 was admitted to the facility on 9/20/18 with a re-admission on 9/29/18. Diagnoses for Resident #46 included tonsil cancer, dysphagia with gastrostomy, gastroesophageal reflux disease (GERD),	F 657	physician orders on a weekday basis Monday through Friday and updating the care plans at that time to reflect any changes in dialysis status and any resident displaying signs/ symptoms of nausea and or vomiting with appropriate goals and interventions. 4. (A/B) On a weekly basis, for 2 months and then monthly then monthly if compliance is met, and the issue resolved, an audit of all current dialysis residents who have had an MDS completed and care plan reviews in that week and any residents exhibiting	

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hypertension and cerebrovascular accident (stroke). The minimum data set (MDS) dated 1/8/19 assessed Resident #46 with moderately impaired cognitive skills.

On 2/24/19 at 3:50 p.m., Resident #46 was observed in bed, leaning over the trash can stating he felt sick on his stomach. Resident #46 stated his stomach "stayed messed up."

Resident #46's clinical record documented ongoing treatment for chronic nausea/vomiting due to status post chemotherapy and radiation due to tonsil cancer. The clinical record documented a physician's order dated 1/18/19 for Scopolamine patch 1.5 mg (milligrams) transdermal every 3 days for nausea/vomiting. There was also a physician's order dated 9/29/18 for Zofran 4 mg to be given every 4 hours as needed for nausea/vomiting.

A physician's progress note dated 1/3/19 documented, "...He has a history of GERD and complains of chronic nausea. He has Zofran ordered as well as scopolamine patches..."

Resident #46's plan of care (revised 2/21/19) included no problems, goals and/or interventions regarding the resident's chronic nausea.

On 2/25/19 at 4:25 p.m., the registered nurse (RN #3) responsible for care plan development was interviewed about Resident #46. RN #3 reviewed the care plan and stated she did not see anything on the plan about the chronic nausea. RN #3 stated revisions to care plans were made as needed by nursing with communication of care areas taking place during morning meetings and from physician orders. RN #3 stated the chronic

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F 657	Continued From page 24 nausea should have been added to the care plan. These findings were reviewed with the administrator and director of nursing during a meeting on 2/25/19 at 5:15 p.m.	F 657		
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 interview, staff interview and clinical record review, the facility staff failed to provide activities of daily living (ADL) care for two of 31 residents in the survey sample. Resident #98's teeth were not brushed/cleaned. Resident #104 was observed with long, dirty fingernails. 1. Resident #98, totally dependent upon staff for ADL care, was observed with unclean teeth. 2. The facility staff failed to ensure Resident #104 was provided ADL (activities of daily living) care to assist with nail care, and meal consumption. The findings include: 1. Resident #98 was admitted to the facility on 9/15/16 with a re-admission on 1/25/19. Diagnoses for Resident #98 included hemiplegia/hemiparesis from cerebrovascular accident (stroke), intracranial injury, cataracts, hypertension, glaucoma, dysphagia, diabetes,	F 677	1. (A) Resident #98 teeth were brushed during the survey and brushed daily. The resident is to be offered daily; when the resident refuses staff have been instructed to return and offer later in the shift. Staff have been instructed to document refusal of care. (B) Patient #104 his nails were trimmed. His nails are to be checked weekly. Kardex's will be updated for Resident #104 reflecting the level of care required to assist with ADLs. 2. All residents requiring assistance with ADLs have the potential to be affected. 3. (A) Staff will be educated: to provide oral care daily, to return to offer the care later when a resident initially refuses, to check the Kardex for resident level of assistance on assigned daily at the start of shift, to provide assistance to residents	4/8/19

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	495151	A. BUILDING ______ B. WING ______	C 02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT LYNCHBURG NURSING & REHABILITATION CENTER	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

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F 677	Continued From page 25 seizures and history of aspiration pneumonitis. The minimum data set (MDS) dated 2/5/19 assessed Resident #98 with moderately impaired cognitive skills and as requiring the extensive assistance of one person for personal hygiene including oral/teeth care. On 2/24/19 at 4:52 p.m., Resident #98 was observed in bed. The resident's teeth had an accumulation of white build-up along the gum line and in between his visible lower front teeth. Resident #98 was interviewed at this time about his teeth. Resident #98 stated his teeth had not been brushed today (2/24/19). Resident #98 stated his teeth were only brushed "every other day" but he did not know why. On 2/25/19 at 4:50 p.m., Resident #98 was observed again with white, accumulated build-up present on his visible lower, front teeth. The white substance was visible along the gum line and in between the teeth. On 2/25/19 at 5:00 p.m., the certified nurses' aide (CNA #1) caring for Resident #98 was interviewed. CNA #1 stated Resident #98 was "total care" and not able to independently brush his teeth. CNA #1 stated that sometimes the resident did not let them brush his teeth. When asked how often she brushed Resident #98's teeth, CNA #1 stated, "Once or twice a week." On 2/26/19 at 8:07 a.m., CNA #2 routinely caring for Resident #98 on the day shift was interviewed about his teeth. CNA #2 stated the resident was totally dependent on staff for oral/teeth care. CNA #2 stated she brushed the resident's teeth each day or as needed whenever she cared for him. CNA #2 stated the resident sometimes	F 677	who require supervision and assistance with meals. (B) The Unit Managers and RN supervisors will ensure the appropriate level of assistance is at meal times. Audits will be done by Unit Managers or DNS designees to assess that care has been completed daily times one week, then 3 times a week for 2 weeks, then weekly for 4 weeks or until resolved. 4. UM and supervisors will report will report the results of the audits to the DNS weekly for 3 months or until resolved. The DNS will report the findings in QAPI monthly x 3 months or until resolved	

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F 677	Continued From page 26 refused oral care because his gums were sore but the refusals were "not often." CNA #2 stated she did not care for Resident #98 yesterday (2/25/19) but had already brushed his teeth today (2/26/19) without any problems. On 2/26/19 at 8:15 a.m., the registered nurse unit manager (RN #4) was interviewed about Resident #98's unclean teeth. RN #4 stated the resident sometimes refused care but not often. RN #4 stated "90% of the time" the resident was cooperative with care if re-attempted. RN #4 stated aides were expected to brush residents' teeth at least twice per day. Resident #98's clinical record documented no refusal of oral care on 2/24/19 or 2/25/19. ADL tracking records from 2/13/19 through 2/25/19 documented daily ADL care including brushing of teeth. The column on this report to indicate resident refusals was blank. Resident #98's plan of care (revised 2/15/19) documented the resident had an ADL self-care deficit due to hemiplegia, limited mobility and brain trauma. Interventions to maintain personal hygiene included, "[Resident #98] requires total assistance with personal hygiene care..." The care plan listed the resident has "tendency to refuse care at times." Interventions to minimize care refusals included, "Anticipate needs...provide opportunity for positive interaction, attention...Discuss behavior with [Resident #98]...Explain/reinforce why behavior is inappropriate and/or unacceptable...Explain all procedures to [Resident#98] to before staring and allow resident time to adjust to changes..." (Sic) These findings were reviewed with the	F 677		

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F 677	Continued From page 27	F 677		

administrator and director of nursing during a meeting on 2/26/19 at 2:15 p.m.
2. Resident #104 was admitted to the facility on 02/07/19. Diagnoses for this resident included, but were not limited to: fracture to right ilium, difficulty walking , muscle weakness, unsteadiness, uropathy, Vitamin D deficiency, glaucoma, and dementia.

The resident's most current MDS (minimum data set) was a 5 day admission assessment dated 02/14/19. This MDS assessed the resident with a cognitive score of "10" indicating moderate impairment of daily decision making skills. The resident was assessed as requiring extensive assistance from at least one staff person for bed mobility, transfers, walking, dressing, toileting, personal hygiene and required total dependence for bathing with one person assist.

Resident #104 was observed on 02/24/19 at 5:00 PM The resident's fingernails were observed visibly soiled under the nails, and the nails were jagged and in need of cutting.

At approximately 5:30 PM on 02/24/19 the resident's wife was interviewed. The resident's wife stated that the resident nails are dirty and that she (the wife) and the resident have been asking to have the nails cleaned and trimmed since he got here. The resident then stated that he had hurt his nail attempting to open a supplement shake carton, that the staff didn't open for him. The resident and wife were asked if assistance had been requested for opening items. The resident stated, "As soon as they [staff] sit the tray down, they're gone...you don't have time to ask for anything."

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F 677	Continued From page 28 The resident's ADL (activities of daily living) records were reviewed, including bathing, and revealed that staff were documenting that the resident was receiving a bed bath daily from 02/14/19 through present. There was not a defined area to document nail care. On 02/25/19 at 7:50 AM, Resident #104 was observed with sputum on side of face/mouth. The resident stated that he could not wipe it himself, although an attempt was made by the resident. The resident was observed in this condition for approximately 30 minutes. A staff member wiped the resident's face at approximately 8:20 AM. Resident #104 was observed multiple time through out the survey from 02/24/19 to 02/25/19 with soiled fingernails and no change in the condition of the nails. On 02/26/19 at 9:02 AM, Resident #104 was observed with his meal tray in front of him, with no food consumed. The administrator was observing from the hall. The administrator was asked to observe the resident and was made aware that this resident was supposed to have assistance with meals. The administrator stated, "Maybe someone assisted... before you got here." The administrator was made aware that the resident's tray had not been touched and was asked to find out if the resident had been assisted. The administrator was also made aware of the resident's fingernails. The administrator observed the resident's fingernails. The administrator was made aware that the resident had been observed since entry to the facility on 02/24/19 and the resident's fingernails had not changed.	F 677		

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F 677	Continued From page 29 The resident's ADL records revealed that the resident had a bed bath everyday from February 13th through February 25th, and bathing total dependence with assist of one for the same dates. The resident's Kardex documented, "...assist with all meals and snack intake...eating...provide diet as ordered...snack...staff to assist with bed bath as required...Assist with ADL's...staff to assist resident with grooming..." The resident's CCP (comprehensive care plan) documented, "...provide and serve supplements as ordered (mighty shake)...monitor intake and record every meal...eating: requires assistance to complete meal...assist with all meals and snack intake...Grooming: assisted by staff..make sure to have proper tools: brush, washcloth, soap, toothpaste...staff to assist with grooming..." On 02/26/19 at 9:15 AM, the administrator was asked about expectation for nail care and for feeding assistance. The administrator stated, "Nail care should be looked at every day and addressed when found to be inappropriate and residents needing assistance with meals should be provided assistance." No further information and/or documentation was provided prior to the exit conference on 02/26/19 at 3:45 PM, to evidence that Resident #104 received appropriate ADL care assistance for nail care and for feeding assistance.	F 677		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		4/8/19

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F 695	Continued From page 30 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, the facility staff failed to obtain a physician order for the administration of supplemental oxygen for one of 31 residents in the survey sample: Resident # 102. Findings include: Resident # 102 was admitted to the facility 12/13/11 with a readmission date of 2/1/19. Diagnoses for Resident # 102 included, but was not limited to: hemiparesis and hemiplegia following a stroke, convulsions, COPD, high blood pressure, and dependence on supplemental oxygen. On 2/24/19 at 3:45 p.m. during initial tour of the facility Resident # 102 was observed sitting in her wheelchair in her room. There was a portable oxygen (02) tank on the back of the wheelchair that was empty; the resident had a nasal cannula hooked to it and the tubing in her nose. LPN (licensed practical nurse) # 1 was asked for assistance with the observation. LPN # 1 stated "Yes, that tank is empty; when the CNA (certified nursing assistant) brought her back to the room she should have been switched over to the oxygen concentrator." LPN # 1 was asked if an 02 saturation (test to measure oxygen in the	F 695	1. Resident #102, O2 saturation immediately checked, saturation 94% The resident was monitored for 3 days to assess the need for oxygen. Patient has consistently maintained an oxygen saturation in the mid-90s on room air. The oxygen concentrator was removed from the room as well as the tank on her chair and will be provided as needed. The resident has orders for 02 checks q shift and oxygen PRN. 2. All residents requiring oxygen have the potential to be affected. 3. (A) All residents utilizing portable oxygen tank will be checked twice a shift. Residents on oxygen sent out to appointments will be provided a full tank of oxygen. (B) The DNS or designee will educate nurses to check orders and administer 02 according to the ordered parameters. Nurses will be educated to document all respiratory care accurately and completely. (C) DNS/designee will perform audits daily	

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F 695	Continued From page 31 body) could be done. The 02 saturation was 95% and LPN # 1 stated "We've been trying to wean her off 02." On 2/25/19 beginning at 7:45 a.m. review of the clinical record revealed no current orders for the administration of oxygen, nor any current orders for weaning the resident off oxygen. The TAR (treatment administration record) was reviewed for January and February 2019. The order on the TAR had a start date of 4/4/18; the February TAR had the order carried forward with a D/C (discontinue) date of 2/1/19. There was an "X" for each day on the February 2019 TAR indicating the oxygen was not documented as being in use. On 2/25/19 at 10:00 a.m. LPN #2 was asked for assistance in locating an order for the oxygen, as well as an order for the discontinuation of it. LPN # 2 stated "It should be on the POS (physician order summary)." She looked through the clinical record and stated "I went back to October of 2018 and I don't see an order for the oxygen." Further review of the record revealed an order on the August 2018 POS for "Oxygen continuous at 2 lpm via nasal cannula...." The POS from September 2018 to current did not have the order for oxygen documented. On 2/25/19 at 10:08 Resident # 102 was observed sitting in her wheelchair in her room. There was a portable oxygen tank attached to the back of the wheelchair. The resident did not have on a nasal cannula, and the oxygen concentrator was not in the room. On 2/25/19 at 4:30 p.m. the DON (director of nursing) was asked about the order for Resident	F 695	x 1 week, then 3 times a week for 2 weeks and then weekly until resolved. Unit Manager or Nursing supervisors to verify the resident is receiving oxygen according to orders. 4. DNS will report findings in QAPI monthly for 3 months or until resolved.	

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F 695	Continued From page 32 # 102's oxygen, and for any order or documentation of weaning the resident off oxygen. She was also asked for a policy on how often and whom was to check the portable oxygen tanks to ensure they were not empty. The DON stated "There is no policy. The expectation is the nurses and CNAs check the tanks daily and change if empty. I did rounds with our NP (nurse practitioner) around the first of February. I remember her saying [name of resident] did not need to use the oxygen anymore since her 02 sats were staying above 90%. One of the other nurses said her sister wanted her to stay on the oxygen. The NP stated she did not need it and d/c'd it that day." The DON looked through the clinical record and stated "I don't see where there's an order on 2/1/19 to d/c the oxygen; I see [name of doctor] d/c'd it today. I'm not sure what happened with that order after August 2018; somebody would have had to go in and take it off the list for it to not show up on the POS." On 2/25/19 beginning at 5:10 p.m. during an end of the day meeting the administrator, DON, and regional nurse consultant were informed of the above findings. No further information was provided prior to the exit conference.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 697		4/8/19

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F 697 Continued From page 33

and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain and administer pain medications as ordered by the physician for one of 31 residents in the survey sample. Resident #46, assessed with ongoing pain related to cancer, was not administered the pain medication Morphine Sulfate as ordered by the physician for five consecutive days.

The findings include:

Resident #46 was admitted to the facility on 9/20/18 with a re-admission on 9/29/18. Diagnoses for Resident #46 included tonsil cancer, dysphagia with gastrostomy, gastroesophageal reflux disease (GERD), hypertension and cerebrovascular accident (stroke). The minimum data set (MDS) dated 1/8/19 assessed Resident #46 with moderately impaired cognitive skills.

Resident #46's clinical record documented a nurse practitioner's progress note dated 1/10/19 stating, "Hx [history] of malignant neoplasms of the tonsil, s/p [status post] chemo and radiation...I asked him on exam if he had pain states 'oh yes'; he does not get into specifics of pain such as quality, severity, duration...facial grimacing on exam...keep the oxycodone as needed as ordered, scheduled Roxanol [morphine sulfate] 10 mg [milligrams] 3 times a day. Rx [prescription] provided..."

A nurse practitioner's progress note dated 1/15/19 documented, "Resident tells me he's in pain...Had written an order for Morphine

F 697

1. Resident #46 was ordered Morphine TID. The medication was obtained on 01/15/2019 and has since received it as ordered.
2. All residents have the potential to be affected if a medication is not available for administration as ordered.
3. Nurses will be educated on the proper procedure when a medication is unavailable, checking the stat box or Omnicell once operational, alerting and working with pharmacy to obtain medication, notifying the MD for additional orders, notifying unit managers and notifying DNS.
DNS or designee will educate staff on the pharmacy policy and procedure for ordering narcotics.
Weekly cart audits will be performed by unit managers for medication availability. The medication carts will be checked for content including adequate supply of medications ordered, expired medications and medication without orders. Pain audits will be performed by the DNS, unit managers or DNS designees.

4. DNS will report findings in QAPI monthly for 3 months or until resolved.

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F 697	Continued From page 34 scheduled on 1/10 [2019]. When I reviewed the MAR [medication administration record], I realized he hadn't been receiving this medication. Resident doesn't get into pain specifics such as quality, severity, duration, etc...Spoke with DON [director of nursing] and unit manager, resident hasn't been receiving. Not sure why? I rewrote another prescription for this Morphine to be given 10 mg TID [three times per day]. This would explain his c/o [complaint of] pain..." The record documented a physician's order dated 1/10/19 for the medication Morphine Sulfate [Roxanol] concentrate (20 mg/milliliter) with 0.5 milliliters to be given three times per day for pain management. Resident #46's MAR for January 2019 documented the resident was not administered the Morphine Sulfate three times as day as ordered from 1/11/19 through 1/15/19. The MAR documented Resident #46 was administered as needed Oxycodone as ordered on 1/12/19, 1/13/19, 1/14/19 and twice on 1/15/19 for pain rated from 6 to 10 (on scale with 0 as no pain, 10 as worst pain). Multiple nursing notes from 1/11/19 through 1/15/19 documented the Morphine Sulfate was "on order" and the facility was "waiting on pharmacy." A note dated 1/15/19 at 10:48 a.m. documented, "Medication not available at facility. MD, DON and Unit manager notified. Will call pharmacy to check on status of medication." The record documented the Morphine Sulfate was not delivered to the facility until 1/15/19 at 8:32 p.m. On 2/26/19 at 12:05 p.m., registered nurse (RN) #1 was interviewed about the missed doses of	F 697		

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F 697	Continued From page 35 Morphine Sulfate for Resident #46. RN #1 stated the order was entered into the computerized record on 1/10/19 but the script was not provided to the pharmacy. RN #1 stated the pharmacy required an actual written script since this was a controlled medication. RN #1 stated she contacted pharmacy and they did not get the script for the controlled medication until 1/15/19. RN #1 presented a copy of the script written by the nurse practitioner on 1/10/19. RN #1 stated she did not know why the script was not sent to the pharmacy on 1/10/19 when the order was placed. RN #1 stated she reviewed the record and did not find anything indicating a reason for the delay. RN #1 again stated she did not know why it took 5 days to get the script for the Morphine Sulfate to the pharmacy. Resident #46's plan of care (revised 2/21/19) listed the resident had pain due to cancer and documented, "Resident reports pain as occurring almost constantly." Interventions to resolve pain and maintain comfort included, "Administer medication as ordered by MD [physician]...Alert MD to unresolved episodes of pain...Reposition as required and during care..." The Nursing 2017 Drug Handbook on pages 998 and 999 describes Morphine Sulfate (Roxanol) as an opioid analgesic used for the management of moderate to severe pain, around-the clock opioid pain management and severe, chronic pain associated with terminal cancer. (1) This finding was reviewed with the administrator and director of nursing during a meeting on 2/26/19 at 2:15 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann	F 697		

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F 697	Continued From page 36 Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 697		
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 in the course of a complaint investigation, facility staff failed to answer call bells in a timely manner throughout	F 725	1. Nursing staff were immediately educated that lunch and breaks are now scheduled and that staff may only go out to smoke on scheduled breaks. Nursing	4/8/19

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F 725 Continued From page 37

the facility.

Facility staff failed to answer call bells in a timely manner as evidenced by individual resident interviews, family interview, group resident interview, and as documented in past resident council meeting minutes.

Findings included:

Resident #97 was interviewed on 02/25/19 at 10:10 a.m. regarding call lights and the aides covering for one another during breaks. Resident #97 stated, "They (CNAs) don't cover for each other. They will come in and say your aide is on break, turn off your light and leave. If you ring on third shift, no one comes. They need more CNAs."

Resident #97's son was interviewed via phone on 02/25/19 at 10:20 a.m. He stated, "Me and my sister [Name] get calls at night around midnight or so from Mom saying I am short of breath and no one is around. We will call at night and the phone rings and rings. No one ever answers. It is especially bad on weekends, mornings and late at night. I have personally seen the aides outside smoking together, walking to the convenience store, and leaving one aide to care for forty patients. That is too much. Since [Company Name] has taken over there have been changes, but there is still a long way to go. I have spoken to the new Administrator and he is trying to make changes."

Review of Resident Council Minutes dated November 27, 2018, December 21, 2018, and January 28, 2019 included the following: "...Residents stated that nursing staff when finally

F 725

staff educated on not only answering the call lights but addressing the patient's needs. Staff will be educated that all are expected to answer call bells.

2. All residents have the potential to be affected.

3. Unit Managers, RN Supervisors and DNS designees will audit response times daily on all shifts 3 times a week for 2 weeks, then weekly for 2 months. Unit Managers and supervisor will provide performance feedback to staff as indicated by findings. UM, RN supervisors and DNS designees will report findings to DNS on weekly basis.

4. DNS will report findings in QAPI monthly for 3 months or until resolved.

F 725 Continued From page 38 F 725

answering residents call bell they have an attitude. Resident's discussed 3rd shift stating they sometimes have fewer CNA's...Resident states he is unable to reach call bell at night. Residents state that it is taking a while for staff to answer call bell at night...Residents state that 2nd shifts still have attitudes when talking to them or call bell is rung. Resident state that call bells need to be answered more timely..." (sic)

A group meeting was held on 02/25/19 at 2:30 p.m. with a member of the survey team. During the meeting, resident's in attendance concurred that when staff call out, it takes a while for staff to answer call lights. It was also stated that the residents feel sorry for the aides that are working because it is too much.

On 02/25/19 at 04:15 p.m., Resident #29 requested to speak to this surveyor. Resident #29 stated, "Something has got to be done. The aides do not help you like they should. You put your light on and nobody comes. I laid here today from 10:00 to 3:00 o'clock in a wet diaper. [Name] CNA [certified nursing assistant] finally came and changed it. I kept going to sleep. I don't know if she just kept turning the light off or what, but each time I woke up I would turn my light back on...11-7 shift is awful. They never answer your light. The aides will all go on break for 30 minutes or longer and never come to help you. It is ridiculous."

During a meeting with the survey team on 02/25/19 at 5:15 p.m. the DON (director of nursing) was interviewed regarding CNA breaks, lunch times and answering call lights. The DON stated, "CNAs have scheduled lunch breaks on the assignment sheet. During breaks they check

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F 725	Continued From page 39 in with the nurse on the floor. They should go one at a time. The nurses and aides or anyone can answer call lights and assist the residents." No further information was received by the survey team prior to the exit conference on 02/26/19. This is a complaint deficiency.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		4/8/19

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F 755	Continued From page 40 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure medications were available for 2 of thirty-one in the survey sample, Resident #29 and Resident #104. 1. The facility staff failed to ensure medications were available for Resident #29 during a medication pass and pour observation, per the physician's order. 2. The facility staff failed to ensure the medications, Aricept and Vitamin D were available for administration for Resident # 104. Findings include: 1. On 02/25/19 at 8:31 AM, a medication pass and pour observation was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 prepared medications for the second resident, Resident #29. LPN #2 stated that this resident gets 1000 mg of gabapentin and normally they (the pharmacy) will send an 800 mg (milligram) pill, but she (the resident) doesn't have any. LPN #2 stated that the resident usually gets one 800 mg pill, along with two 100 mg capsules to equal 1000 mg dose, as ordered by the physician. LPN #2 stated that the resident does have the 100 mg capsules and stated, "I'll just give her 10 [capsules]." LPN #2 popped 10 gabapentin capsules from the medication card into a plastic dispensing cup. LPN #2 finished preparing the	F 755	1. Gabapentin 800mg capsules was obtained from the pharmacy for Resident #29 and currently available for administration. The cart was checked and the Aricept for Resident #104 was delivered on 02/21/2019, available on the cart at the time of the med pass observation but the nurse did not locate it. The Vitamin D was house stock and 2 bottles of it was on the cart at the time of the med pass observation, the nurse did not locate it nor check medication storage. 2. All residents on medications have the potential to be affected. 3. Nurses will be educated of the proper procedures to obtain medications including checking the stat box or (Omnicell once operational), calling the pharmacy, calling the MD for alternate orders, notifying unit managers and notifying DNS. Staff will be also educated on the pharmacy policy and procedure for ordering narcotics. DNS/designee will review new orders in the clinical meeting to verify medications have been obtained and the 24-hour report will be reviewed to verify medications reordered have been received. Nurses will be educated to check the cart thoroughly and check the stock med list and medication storage	

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F 755	Continued From page 41 medications and took the medications into the room to the resident. LPN #2 told the resident that the gabapentin 800 mg was not here and handed Resident #29 10 gabapentin 100 mg capsules and stated, "I have ten of these for you." The resident stated, "Ten." The LPN stated, "Yes, ten." The resident stated, "That's a lot of pills." Resident #29 took the medications without difficulty and then stated, "Why can't they check on this before hand and get that ahead of time, that's a lot of pills." The resident was laying in bed with her breakfast on the overbed table. The resident was asked if she was going to eat her breakfast now and the resident stated, "I don't know if I am or not now." On 02/25/19 at approximately 9:40 AM, a medication reconciliation was completed on Resident #29. The physician's orders included an order for, "GABAPENTIN 800 MG TABLET 1 TAB BY MOUTH THREE TIMES DAILY...GABAPENTIN 100 MG CAPSULE 2 CAPS BY MOUTH THREE TIMES DAILY..." On 02/25/19 at 11:42 AM, LPN #2 was interviewed regarding the above information. LPN #2 was asked to look at Resident #29's gabapentin medication and why the resident would be administered ten pills. LPN #2 stated, "It isn't usually like that, but I don't know why they (pharmacy) didn't send it, I honestly don't know." LPN #2 was asked if she could determine if the medication had been ordered and LPN #2 then looked up the medication and stated that it had not been reordered since 01/24/19. The administrator, DON (director of nursing) and the corporate nurse were made aware of the issue in a meeting with the survey team on	F 755	room for stock meds as well. 4. DNS will report findings in QAPI monthly for 3 months or until resolved.	

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F 755	Continued From page 42	F 755		

02/25/19 at 5:45 PM. The administrator stated that the expectation is for nurses to reorder medications timely to ensure that physician ordered medications are readily available for administration.

No further information and/or documentation was presented prior to the exit conference on 02/26/19 at 3:45 PM to evidence facility staff ensured medications were available for administration per physician's orders.

2. Resident #104 was admitted to the facility on 02/07/19. Diagnoses for this resident included, but were not limited to: fracture to right ilium, difficulty walking , muscle weakness, unsteadiness, uropathy, Vitamin D deficiency, glaucoma, and dementia.

The resident's most current MDS (minimum data set) was a 5 day admission assessment dated 02/14/19. This MDS assessed the resident with a cognitive score of "10" indicating moderate impairment of daily decision making skills. The resident was assessed as requiring extensive assistance from at least one staff person for bed mobility, transfers, walking, dressing, toileting, personal hygiene and required total dependence for bathing with one person assist.

During clinical record review, Resident #104's nursing notes were reviewed from admission (02/07/19) through present.

An eMAR-Medication Administration Note dated 02/24/19 11:47 documented, "Aricept not available to administer, on order from pharmacy...2/24/2019 11:46 eMAR-Medication Administration Note...Vitamin d3 not available to

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F 755	Continued From page 43 administer..." Resident #104's physician's orders were reviewed and included an order for, but not limited to: "...Aricept 10 mg...one time a day for dementia...Vitamin D3 Capsule 400 UNIT Give 1 capsule by mouth one time a day for Vit D deficiency..." The MARs (medication administration records) were reviewed and documented a "9" (see nursing notes) on 02/24/19 for the medication Aricept and Vitamin D3. The DON (director of nursing), administrator, and corporate nurse were made aware in a meeting with the survey team on 02/25/19 at 5:45 PM. A policy was requested on medications being available for administration for residents. The policy was provided on 02/26/19 at approximately 9:15 AM. The policy documented, "... reorders can be written...can be submitted verbally...can be faxed...electronic orders...electronically reorder resident medications...facility staff should reorder medications using an electronic list of residents and medications due or use of barcode technology...staff should select needed refill orders from a list...should review the transmitted order is confirmed for status and potential issues and pharmacy response...staff should use...to review the status of open orders for follow up with pharmacy..." The administrator stated that the expectation is for nurses to reorder medications timely to ensure that physician ordered medications are readily	F 755		

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F 755	Continued From page 44 available for administration. No further information and/or documentation was presented prior to the exit conference on 02/26/19 at 3:45 PM to evidence facility staff ensured medications were available for administration per physician's orders.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		4/8/19

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F 756	Continued From page 45 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff failed to act upon pharmacy recommendations for one of 31 residents in the survey sample, Resident #81. Facility staff failed to respond to a pharmacy request dated 02/01/2019 and 02/18/2019 for Resident #81. Findings included: Resident #81 was admitted to the facility on 01/26/2019 with diagnoses including, but not limited to: Radiculopathy of the Lumbar Region, Dementia with Behaviors, Encephalopathy, Hypertension, and Osteoarthritis. The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 02/02/2019. Resident #81 was assessed as severely impaired in her cognitive status with a total cognitive score of four out of 15. Resident #81's clinical record was reviewed on 02/26/2019 at approximately 9:00 a.m. During this review two pharmacy review notes were	F 756	1. Resident #81 recommendations were obtained and immediately given to the MD for review during survey on 02/25/2019. 2. All residents have the potential to be affected. 3. The pharmacy representative was notified of the change in DNS and to send reports via email to the new DNS. The DNS will print them and give to the MD for review. Once reviewed by the MD the Unit Managers and RN supervisors will verify all recommendations have been noted. The DNS will verify that all recommendations have been returned. 4. The DNS will report findings in monthly QAPI for 3 months or until resolved.	

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F 756	Continued From page 46	F 756		

observed and included the following: "2/1/2019 23:13 [11:13 p.m.], Consulting Pharmacist...An admission/re-admission pharmacy medication regimen review was done using the EMR [electronic medical record]. [X] See report for any noted irregularities and/or recommendations...and 2/18/2019 15:39 [3:59 p.m.], Consulting Pharmacist...This monthly pharmacy medication regimen review was done using the EMR. [X] See report for any noted irregularities and/or recommendations..." The actual reports could not be located in the clinical record.

At approximately 10:00 a.m. the DON (director of nursing) was interviewed regarding the location of pharmacy recommendation reports. The DON stated, "I am not sure. I have not seen any pharmacy reports or received any emails from the pharmacy. I have a book here of reports, but they are from 2018." At approximately 10:45 a.m. the DON provided a copy of the pharmacy recommendations dated 02/18/19.

During a meeting with the survey team at approximately 11:30 a.m., the DON stated, "The reports were going to [Name] [Former DON] email. [Name] [Pharmacist] is going to send them to me. This is the only pharmacy recommendation I have. I have placed the report in the doctor's folder to review."

During a later meeting with the survey team at approximately 2:00 p.m., the DON stated, "[Name] [Pharmacist] is sending me all the pharmacy recommendations for this year. It is slow going because they are coming one by one. All the recommendations will be placed in the doctor's folder for review."

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F 756	Continued From page 47 The Administrator was advised of the above information during a meeting with the survey team on 02/26/19 at approximately 2:00 p.m. No further information was received by the survey team prior to the exit conference on 02/26/19.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication administration observation, staff interview and clinical record review, facility staff failed to ensure a medication error rate of less than five percent in the facility. There were two medication administration errors out of 30 opportunities total, resulting in an overall medication error rate of 6.67 %. The Findings Include: During medication pass and pour observation conducted on 02/25/19 at 8:12 AM, Resident #37 was observed receving medications. The labels on two medications were observed. One label instructed "Carvedilol (Coreg) 3.125 MG (millagrams) give two tablets twice a day" (given for hypertension); the second instructed "Allopurinol 100 MG give two tablets twice a day" (given for hyperuricemia). Registered nurse (RN) #2 was observed putting one of each tablet into a dispense cup. Then RN	F 759	1. Staff will be educated on medication administration policy and procedure with competency exam. DNS/designee will conduct med pass observation on licensed staff. 2. All residents have the potential to be affected. 3. Unit Managers and RN supervisors will conduct random med pass observations on each shift weekly for a month, then once a month on a ongoing basis. 4. The DNS will monitor this process and report findings in a QAPI for three months or until resolved.	4/8/19

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F 759	Continued From page 48	F 759		

#2 picked up the medication cup and began to enter Resident #37's room. At this time this surveyor stopped RN #2 and asked RN #2 to recheck the medication label for Coreg and Allopurinol. This surveyor pointed out that according to the medication labels Resident #37 should be receiving 2 tablets of Allopurinol and 2 tablets of Coreg.

RN #2 verbalized she had not seen what the instructions on the labels read, and thought Resident #37 was to receive only one tablet of each medication. RN #2 then counted the pills in the dispense cup and against the pills ordered to be given and verified that there was only one Coreg and one Allupurinol in the dispense cup.

This surveyor then asked RN #2 to verify the Medication Administration Record (MAR) against the acting physician orders. The physician orders read "Allopurinol Tablet 100 MG Give 2 tablets by mouth two times a day for Hyperuricemia...Coreg Tablet 3.125 MG Give 2 tablet by mouth two times a day for HTN [hypertension]."

RN #2 verbalized that she didn't pay attention and only thought one pill of each was to be given.

On 02/25/19 at 5:12 PM, the director of nursing and administrator were informed of the above finding.

No other information was presented prior to exit conference on 2/26/19.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/8/19

§483.45(g) Labeling of Drugs and Biologicals

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	495151	A. BUILDING ______ B. WING ______	C 02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT LYNCHBURG NURSING & REHABILITATION CENTER	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 761	Continued From page 49 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to ensure expired over the counter medications were not available for distribution on one of 4 medication carts. Four bulk over the counter (OTC) medications were expired and available for distribution on the Brookside medication cart. The Findings Include: On 02/25/19 at 2:14 PM, the Brookside medication cart was reviewed and evidenced the	F 761	1. All medication carts were checked and any expired medications were removed. 2. All residents have the potential to be affected. 3. (A) Nurses will be educated on the process for checking for expired and inactive medications for removal from the cart. Night nurses will check the carts weekly and remove any expired non-narcotic medications on an ongoing basis. Night nurse will notify DNS or Unit	

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F 761	Continued From page 50 following expired medications: Vitamin C 1000 MG (Milligrams) expiration 12/2018, Antihistamine Allergy relief expiration 8/2018, Multivitamin expiration date 9/2018, and Vit B-12 500 MCG (Micrograms) expiration date 11/2018. License practical nurse (LPN) #3 was present during the observation and confirmed the medications were expired and available for distribution. When asked how nurses ensure that expired medications are not available for distribution, LPN #3 verbalized each nurse is responsible for checking for expired medications on a daily basis. On 02/25/19 at 5:12 PM, the above information was brought to the attention of the director of nursing (DON) and administrator during an end of day staff meeting. When asked what the expectation is regarding available expired medications the DON verbalized night shift should be looking for expired medications. The administrator was asked for a policy regarding storing medications. On 02/26/19 the facility presented a policy regarding storage and expiration dates of drugs and biological's which read in part "[...] Have an Expiration Date on the label; Have not been retained longer than recommended by the manufacturer or supplier guidelines; [...]" No other information regarding this concern was provided prior to exit conference on 2/26/19.	F 761	Managers of any narcotic which need to be removed and destroyed. (B) Unit Managers will randomly audit medication cart weekly for 1 month, then 2 times a month on a ongoing basis. 4. DNS will report findings in monthly QAPI for 3 months or until resolved.	
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.	F 842		4/8/19

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F 842	Continued From page 51 (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 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.	F 842		

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F 842	Continued From page 52 §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. 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 two of 31 residents in the survey sample. 1. Resident #46's clinical record failed to document a physician's order for hospice services. 2. Resident #78's clinical record inaccurately documented physician orders for contact precautions.	F 842	1. (A) The hospice order was reentered for Resident #46. The nurse was reeducated on correctly reentering hospice orders. The nurse erroneously entered the hospice order with a 3-day stop. (B) Resident #78's urine was tested on 02/26/2019 and urine was no longer positive for ESBL. The resident's surgical wound had healed. The infection control precautions were discontinued on 02/28/2019 when urine culture report received.	

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F 842 Continued From page 53

The findings include:

1. Resident #46 was admitted to the facility on 9/20/18 with a re-admission on 9/29/18. Diagnoses for Resident #46 included tonsil cancer, dysphagia with gastrostomy, gastroesophageal reflux disease (GERD), hypertension and cerebrovascular accident (stroke). The minimum data set (MDS) dated 1/8/19 assessed Resident #46 with moderately impaired cognitive skills.

Resident #46's clinical record documented a change in payer source of 2/15/19 from Medicaid only to Medicaid plus hospice. The resident's clinical record documented no physician's order for hospice care.

A social worker note dated 2/12/19 documented a discussion with Resident #46's family regarding hospice services. This note stated, "...SW [social worker] tentatively scheduled the meeting with hospice on 2/15/19 at 1:30 p.m." There was no further documentation in the clinical record indicating an outcome of this meeting. There was no documentation in the record indicating hospice services were ordered by the physician.

On 2/25/19 at 4:06 p.m., the business office manager was interviewed about Resident #46's listed payer source. The office manager stated she got an email from the social worker stating the resident started hospice services on 2/15/19. The office manager stated she changed the payer source for Resident #46 to hospice starting on 2/15/19 based upon the email notification.

On 2/25/19 at 4:36 p.m., the social worker was interviewed about hospice services for Resident

F 842

2. Residents on hospice and infection control precautions have the potential to be affected.

3. Licensed staff will be educated on correct procedure for entering hospice orders and correct procedure for discontinuing precautions. Orders will be reviewed in morning clinical meeting to verify hospice orders have been correctly entered. Unit Managers will be responsible for reviewing labs, symptoms and adhering to infection control guidelines when discontinuing infect control precautions.

4. DNS/SDC will review each resident as to verify infection control guidelines have been followed.

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F 842	Continued From page 54 #46. The social worker stated the family met with the hospice representative on 2/15/19 as scheduled. The social worker stated the hospice representative reported to her on 2/15/19 that the resident was entered into hospice care. The social worker stated she reported this to the business office and the unit manager. The social worker stated hospice required a physician's order but she did not know why the order was not in Resident #46's clinical record. On 2/25/19 at 4:54 p.m., the social worker stated she investigated and found that the order for Resident #46's hospice was entered into the computer incorrectly. The social worker stated the hospice order was entered on 2/15/19 as a one-time only "completed" order and therefore did not show in the record. The social worker stated the order should have been entered as an active order without a stop date as hospice services were ongoing. These findings were reviewed with the administrator and director of nursing during a meeting on 2/26/19 at 2:15 p.m. 2. Resident # 78 was admitted to the facility on 6/6/17, and most recently readmitted on 1/29/19 with diagnoses that included anemia, septicemia, diabetes mellitus, Non-Alzheimer's dementia, volvulus, generalized muscle weakness, esophageal obstruction, colostomy placement, muscle wasting and atrophy, nontraumatic perforation of the intestine, pneumonitis, and metabolic encephalopathy. According to a Medicare 5-Day Minimum Data Set, with an Assessment Reference Date of 2/5/19, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 6 out of 15.	F 842		

F 842 Continued From page 55 F 842

During review of Resident # 78's Electronic Health Record (EHR), the following order was noted under the "Orders" Section, "Contact precautions for MRSA (Methicillin Resistant Staphylococcus Aureus) abdominal wound." The order was dated 2/25/19.

Observation of the resident's room on the morning of 2/25/19 noted a sign on the door indicating contact precautions were in effect, and there was a panel hanging on the door containing personal protective equipment items.

At 10:45 a.m. on 2/25/19, LPN # 3 (Licensed Practical Nurse) was asked the source of Resident # 78's MRSA. "I think it's in his urine," LPN # 3 replied.

At 10:55 a.m. on 2/25/19, RN # 1 (Registered Nurse), who is also the Infection Control Nurse, was asked the source of Resident # 78's MRSA. "I'm not sure, but I will check on it," RN #1 replied.

Review of the Electronic Medication Administration Record in Resident # 78's EHR revealed he was not currently on any antibiotics.

Further review of Resident # 78's EHR revealed a Surgical Consultation Report, dated 2/4/19, that noted, "Incision healing well without signs of infection...sutures removed today."

On 2/26/19 at 10:15 a.m., review of the resident's EHR noted that the contact precautions order in the "Orders" section of the EHR was no longer displayed. When interviewed about the removal of the contact precautions order, the Director of Nursing (DON) said "...the resident did have a

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F 842	Continued From page 56 mid-line abdominal wound that is healed. Contact precautions were discontinued." Asked why the contact precautions order was no longer listed, the DON said, "When an order is D/C'd (discontinued), it is removed from the orders section." During a meeting at approximately 1:30 p.m. on 2/26/19, that included the Administrator, DON, two corporate nurse consultants, and the survey team, the DON was asked again about the contact precautions order. Asked specifically who discontinued the contact precautions order, the DON said, "I did. It (the order) was in error."	F 842		
F 925 SS=C	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, staff interview, and review of facility documents, the facility failed to maintain an effective pest control program. Between 7/31/18 and 12/11/18, there were 20 Service Request Log entries for cockroaches in various areas of the facility. The findings were: In the course of a complaint investigation, the Maintenance Director was interviewed regarding cockroaches in the facility, particularly in late August and early September of 2018. "We had a problem with roaches late last Summer," the Maintenance Director said. He went on to explain that a car used by a resident who still drove, and	F 925	1. ECO lab came to service building on 03/15/2019. 2. (A) The facility has contracted with Ecolab to come monthly to treat to eradicate the cockroaches which began 07/31/2018. (B) The facility staff have been in-services by Maintenance Director and Administrator on communicating pest findings on the pest control book for review. 3. Ecolab will visit and service the facility on a monthly basis to maintain an effective pest control service for	4/8/19

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F 925	Continued From page 57 which was parked behind the building, was infested with roaches. Continuing, the Maintenance Director said, "We found out the roaches were coming in on the resident and on items he was bringing in to the building. Ecolab (the pest control company) came out and fumigated the whole building." The Maintenance Director indicated the fumigation resolved the cockroach problem. At the request of the surveyor, the Maintenance Director provided the pest control book for review. Included in the book was a Service Request Log. Review of the Service Request Log for the period 7/3/18 through 12/11/18 revealed the following: 7/31/18 - Roaches in Brookside (nursing unit) shower room 8/10/18 - Roaches in Kitchen 8/17/18 - Roaches at Ice Machine (NOTE: The Ice Machine is located adjacent to the Kitchen.) 8/21/18 - Roaches in laundry 8/26/18 - Roaches at Ice Machine 9/1/18 - Roaches in a resident room 9/6/18 - Roaches in two resident rooms 9/10/18 - Roach eggs found at stairway door 9/12/18 - Roaches in Kitchen and Dry Storage Room 9/12/18 - Roaches in Conference Room 9/24/18 - Roaches in Therapy Room 10/2/18 - Roaches in a resident room 10/2/18 - Roaches in the Minimum Data Set office 10/11/18 - Roaches in Kitchen on service line 10/12/18 - Roaches on the Riverside (nursing) Unit 10/17/18 - Roaches on the Twin Lakes (nursing) Unit 10/25/18 - Roaches at the Reception Desk 10/25/18 - Roaches in the Activity Room	F 925	cockroaches identified by the facility on 07/31/2018 to assure proper oversight of prior cockroach program. 4. The results of any findings will be reported to the QAPI committee on a monthly basis for 3 months for recommendations and follow-up.	

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F 925	Continued From page 58 10/30/18 - Roaches in Employee Break Room 12/11/18 - Roaches on counter top in Therapy Room In total, there were 20 service requests concerning cockroaches between 7/31/18 and 12/11/18. Also reviewed was a Service Report dated 1/22/19 that noted the following: "Cockroaches reported in Breakroom, Garbage area, Kitchen area, Office area. Treatments done using Advion Cockroach Gel Bait, and Arilon Insecticide." During a meeting at approximately 1:30 p.m. on 2/26/19, that included the Administrator, DON, two corporate nurse consultants, and the survey team, the lack of an effective pest control program was discussed. COMPLAINT DEFICIENCY	F 925		