STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/14/19 through 5/16/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. Four complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/14/19 through 5/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 22 current Resident reviews and 4 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to ensure reasonable accommodations of needs for the use of a urinal for one of 26 residents in the survey sample, Resident #4.	F 558	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken	6/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/28/2019

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 558	Continued From page 1 Resident #4's urinal was in a plastic bag on the side of the resident's bed; the resident could not get the urinal out of the bag and urinated on himself in the process. The findings include: Resident #4 was originally admitted to the facility on 5/2/17, with the current readmission on 3/22/19. Diagnoses for this resident included, but were not limited to: heart failure, high blood pressure, BPH (benign prostatic hyperplasia), GERD (reflux), DM (diabetes mellitus), arthritis, hemiplegia, hemiparesis, anxiety disorder, and depression. This resident suffered a stroke, which resulted in slow communication and total right sided weakness. The most recent MDS (minimum data set) was an annual assessment dated 5/4/19. The resident was assessed on the BIMS (brief interview for mental status) as scoring 15, indicating the resident was intact for daily decision-making skills. The resident was coded as supervision with one person for bed mobility, walking in room and corridor, dressing, toileting and hygiene. Supervision with extensive assistance for transfers and bathing. The resident was coded as having upper and lower body impairments. The resident was additionally coded as occasionally incontinent (less than 7 episodes) and always continent for bowel. The resident triggered in the CAAS (care area assessment summary) section of this MDS for, but not limited to: communication, ADL, urinary, mood, and falls. 05/14/19 12:31 PM, Resident #4 was interviewed in his room. The resident was lying in bed,	F 558	or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F 558 1) Resident #4 urinal was removed from bag and placed in residents preferred space. Care plan updated to ensure consistency of preferences. 2) All residents who use a urinals. 3) Staff Development Coordinator or designee will provide education to all nursing staff regarding urinal placement for residents in their preferred areas. 4) DON or designee will audit 100% of all resident using urinal for preferred placement, then 50% 2x a week for 2 weeks, then 25% 2x week for 2 weeks, then review findings in QA 5) Date of Compliance: 6/5/19	

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F 558	Continued From page 2	F 558		

dressed with TED hose, socks and shoes on. Approximately 10 minutes into the interview, LPN (licensed practical nurse) #4 entered the room. The resident reported to this LPN that staff had put his urinal in a bag on the side of his bed last night, he couldn't get it off, he wet himself, and his wet clothes are over in the floor in a bag. The resident stated that the CNA (certified nursing assistant) didn't pick them up. LPN #4 stated that she would pick them up and left the room.

When asked about the above incident, Resident #4 stated he didn't know why they did that (put his urinal in a bag), but it is difficult enough to get the urinal without fighting a bag. The resident stated that they (staff) often don't empty the urinal and he will get mad and usually empties it himself. Resident #4 stated that he could get around pretty good and do a lot for himself if things are set up and where they should be for him to be able to be as independent as possible.

On 05/16/19 07:55 AM the resident was interviewed again about his urinal. Resident #4 stated that they (staff) don't usually check the urinals to see if I've used it in the night. The resident stated that they (staff) have never put a bag on the urinal before and he wasn't sure why that happened. The resident's urinal was observed, empty on resident's left side of the bed.

On 05/16/19, 08:03 AM CNA (certified nursing assistant) #6 was interviewed about residents who use urinals. The CNA stated that the urinals are kept in a bag in the bathroom or near the bed in a bag. The CNA stated that Resident #4 likes his by the bed. The CNA was asked the purpose of the urinal being kept in a bag. CNA #6 stated that 'it keeps urine from dripping on stuff' and that

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Resident #4 takes his out of the bag to use it. The CNA was asked if that was a policy or if that is just what was done, the CNA stated that it was a policy for urinals and bedpans to be in bags.

The DON (director of nursing), the corporate nurse and administrator were asked for a policy during a meeting with the survey team on 5/16/19 at approximately 9:00 AM. A policy for storage and care of urinals was requested.

The DON stated that she didn't think that there is a policy on urinals, but the expectation is for the urinal to be easily accessible for use and CNA's/nurses should be making rounds on these residents every two hours to ensure they are being taken care of.

The resident's current physician's orders were reviewed and documented the resident receives finasteride 5 mg (milligram) once a day and Flomax 0.4 mg once a day for BPH.

The resident's current CCP (comprehensive care plan) documented in part: "..ADL deficit related to right sided weakness due to previous stroke...assist bars to bed...assist with toileting as needed...anticipate and meet the resident's needs...instructed resident to use urinal...at night...has episodes of bladder incontinence related to impaired mobility, BPH...ensure resident has unobstructed path to the bathroom..provide per care as needed..."

On 5/16/19, the DON stated again, "No policy on urinals. Expectation would be to have urinal where resident prefers the expectation is for it [urinal] not to be in a bag, staff should be emptying the urinal if it has urine and returning it

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F 558	Continued From page 4 to the location for use, the staff are expected to make rounds every two hours on residents." No further information and/or documentation was presented prior to the exit conference on 5/16/19.	F 558		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow professional standards of practice during medication administration for one of 26 residents in the survey sample, Resident #23. The medication Trelegy Ellipta was administered without any instruction or prompt from the nurse, for Resident #23 to rinse her mouth with water following inhalation of the medicine as recommended by the manufacturer. The findings include: A medication pass observation was conducted on 5/15/19 at 7:38 a.m. with licensed practical nurse (LPN) #2 administering medications to Resident #33. Among medications administered was Trelegy Ellipta 100 mcg [microgram]/62.5 mcg/25 mcg with use of an inhaler device. Resident #33 did not rinse and spit after the administration of the Trelegy Ellipta and was not instructed or prompted by LPN #2 to rinse her mouth following the medication.	F 658	F 658 1) Resident #23 orders currently updated to include additional instructions to rinse after usage of steroidal inhaler. 2) All residents using steroid inhalers. 3) Staff Development Coordinator or designee will educate all medication administration nurses on providing instruction/opportunity to rinse mouth after use of steroidal inhaler. 4) DON or designee will audit 100% of current residents with steroidal inhalers for inclusion of (rinse mouth after use) instructions, then complete 7 med pass observations that include patients with steroidal inhalers a week for 2 weeks, then 5 med pass observations for 2 weeks, then review findings in QA. 5) Date of Compliance: 6/5/2019	6/5/19

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Resident #33's clinical record documented a physician's order dated 4/18/19 for Trelegy Ellipta Aerosol Powder Breath Activated 100/62.5/25 mcg/inhale with instructions for one inhalation orally each day for treatment of COPD (chronic obstructive pulmonary disease).

On 5/15/19 at 8:35 a.m., LPN #2 was interviewed about the Trelegy Ellipta administered without a prompt for rinsing. LPN #2 stated he offered the resident a sip of water after the administration of Trelegy Ellipta but did not instruct or prompt her to rinse and spit. LPN #2 stated he knew that (Trelegy Ellipta) was a medication that required a mouth rinse. LPN #2 stated, "You made me nervous."

The manufacturer's documentation describes Trelegy Ellipta as a combination corticosteroid, anticholinergic and vilanterol medication used for the long-term treatment of COPD. The manufacturer's instructions for administration documented, "Trelegy Ellipta should be administered as 1 inhalation once daily by the orally inhaled route only. After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis." (1)

This finding was reviewed with the administrator and director of nursing during a meeting on 5/15/19 at 5:15 p.m.

No further information was provided.

(1) Trelegy Ellipta. 2018. Glaxo Smith Kline, Research Triangle Park, NC. 5/17/19. www.trelegy.com/

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F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, and clinical record review, the facility staff failed to ensure one of 26 residents was provided accommodations to ensure individual activity interest were provided for Resident #15. The facility failed to ensure Resident #15 was provided accommodations for meeting the individual's activity preference based upon the resident's assessment. The findings include: Resident #15 was admitted to the facility on 3/18/19. Diagnoses included but were not limited to: high blood pressure, major depressive disorder and Parkinson's disease. The most current MDS (minimum data set) was a quarterly assessment dated 2/20/19. This MDS assessed the resident with a cognitive score of 14 on the BIMS (brief interview for mental status), indicating the resident is intact for daily	F 679	F 679 . 1) Resident #15 is being provided with preferred activity opportunities per care plan, including visits outside on her patio. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all licensed staff, CNA□s and activities staff on providing preferred activities based on care planned assessment. 4) Activities Director or designee will audit 100% of current resident□s for an appropriate individualized activity care plan, then audit 25% of residents individualized care plans for implementation weekly x2 weeks then 10% weekly x2 weeks, then review findings in QA. 5) Date of Compliance: 6/5/2019	6/5/19

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F 679	Continued From page 7 decision-making skills. The resident was coded as supervision with one person assist for transfers and as supervision with set up only for walking in and in corridor, locomotion on and off unit and as not steady, but able to stabilize without staff assistance for 'balance during transitions and walking'. The resident's mode of transportation was documented as a walker. A significant change assessment for this resident dated 7/20/18 documented in Section F0500. 'Interview for Activity Preferences' as 'very important' for favorite activities and being able to go outside to get fresh air when the weather is good. Resident #15 and the resident's daughter was interviewed on 5/14/19 at approximately 3:00 PM. The resident stated that she wanted to know how long you had to be punished for having a fall. The resident went on to say that, she had a fall about a year ago on the patio and since then they will not allow the resident to go on the patio. The daughter stated that she will take the resident out some, but did not know the last time staff took the resident out. The resident stated that she could not remember the last time staff had taken her out on her patio. The resident's CCP (comprehensive care plan) was reviewed and documented, '...support self-directed, independent leisure...activities...attain or maintain highest practical well being through activities of choice 1-5 x weekly to maintain quality of life...honor patient's preferences of leisure activities...enjoy time on her outside porch...Falls...keep environment free of trip hazards...assistance with watering flowers on patio safely...will have	F 679		

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F 679	Continued From page 8 someone with her at all times when outside, staff to open patio door for her when she goes out...' The resident stated that the staff took her key and that she really has not been able to go out on the patio for almost a year, other than when her daughter has taken her out. A phone interview with the resident's daughter was conducted on 5/16/19 at 10:20 AM. The daughter stated that when her mother fell that we (she and staff) thought that it was best, but stated that it has been almost a year and that she wants her mother to be happy and that (going out on the patio) is something that the resident enjoys. The daughter stated that she felt that staff don't take her out is because they are short staffed. On 5/16/19 at 10:40 AM, the DON and corporate nurse were made aware in a meeting with the survey team. The DON stated that staff are supposed to take her (Resident #15) out. On 5/16/19 at 10:50 AM, the activity director was interviewed and stated that she didn't take this resident out on her porch, she will take her out front with other residents as a group activity and stated that the CNA's (certified nursing assistants) are supposed to take her (Resident #15) out. The activity director stated that the resident has to ask to go out. The activity director was asked for documentation for Resident #15 for individual activities for porch sitting from 2018 to present. The DON and corporate nurse were made aware of the above information. The DON stated, "We have no documentation at all on taking her out." The DON stated that she thought that this was	F 679		

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F 679	Continued From page 9 important and should be documented, but that it wasn't. The DON could not provide evidence that CNA's were taking this resident out at all. The activity director returned documentation at 11:15 AM for March 2019 through May 2019. The documentation did not evidence any individual activity for the resident, specifically for patio sitting in her private area. No further information and/or documentation was presented prior to the exit conference on 5/16/19 to evidence that the resident was provided and assisted with individual activity interest that were important to the resident.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for treatment and care of skin integrity to promote healing and prevent the	F 686	F 686 1) Resident #287, MD was made aware of bed not functioning, bed was assessed and returned to working order.	6/5/19

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F 686	Continued From page 10 development of pressure sores for one of 26 residents in the survey sample, Resident #287. The facility staff failed to ensure Resident #287's physician ordered air mattress was on and functioning. The findings include: Resident #287 was admitted to the facility on 4/26/19. Diagnoses for Resident #287 included; Multidrug-resistant organism, quadriplegia, osteomyelitis, open wound to left hip. The most current MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 5/3/19. Resident #287 was assessed with a score of 15 on the BIMS (brief interview for mental status) indicating cognitively intact. On 05/14/19, at 12:00 PM, Resident #287 was interviewed. When asked if everything was in working order in the room where Resident #287 resides, Resident #287 stated the air mattress hasn't worked since he was moved to the room on 5/13/19. Observation of the air mattress control panel revealed that the air mattress was not turned on. On 05/14/19 at 12:19 PM, certified nursing assistant (CNA #1, assigned to Resident #287) was asked to observe the air mattress in Resident #287's room. CNA #1 checked the connections of the air mattress then turned the air mattress on. CNA #1 stated that she had been in Resident #287's room earlier but did not notice that the air mattress was off and stated that the air mattress needed to be on. On 5/14/19 Resident #287's medical record	F 686	2) All residents with air mattresses are at risk. 3) Staff Development Coordinator or designee will educate all nursing staff on following physician orders for pressure relief management, and ensuring equipment is in working order. 4) DON or designee will audit 100% of current residents with air mattresses for appropriate orders and function of mattress equipment, then 100% weekly for 4 weeks, and review findings in next QA. 5) Date of Compliance: 6/5/2019	

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F 686	Continued From page 11 evidenced (via physician's order), "air mattress every shift." the order had been in effect since 4/27/19. Resident #287's care plan (dated 4/30/19) was also reviewed and indicated an air mattress was to be put in place due to pressure ulcer to the left buttock. On 05/15/19 at 5:15 PM, the above information was presented to the director of nursing (DON) administrator and nurse consultant. The nurse consultant verbalized awareness of the concern and verbalized that the air mattress is working now. No other information was presented prior to exit conference on 5/16/19.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		6/5/19

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F 690	Continued From page 12 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and medical record review, the facility failed to ensure appropriate treatment and services were provided concerning intermittent catheterization for one of 26 Resident's, Resident #68. and failed to ensure proper placement of a catheter bag for one of 26 Resident's, Resident #7 1. Resident #68 did not receive intermittent catheterization as ordered by the physician. 2. Resident #7's catheter bag was placed in the bed beside Resident #7. The findings include: 1. Resident #68 was admitted to the facility on 3/8/19. Diagnoses for Resident #68 included: Pneumonia, neuromuscular bladder dysfunction, respiratory disorder, and reflux. The most current MDS (minimum data set) was a 30 day assessment with an ARD (assessment reference	F 690	F 690 1) Resident #68 is no longer in center. Resident #7 has been provided leg bag as desired during the day and educated on proper placement when in bed. 2) All residents with catheters are at risk. 3) Staff Development Coordinator or designee will educate all nursing/therapy staff: a. On proper placement of catheter bags when residents are in bed. b. Ensuring intermittent catheterization occurs per physician order. 4) DON or designee will audit: a. 100% of current residents with catheters for proper placement of foley bag 5x weekly for 2 weeks, then 50% of residents for 5x weekly for 2 weeks, review findings during next QA meeting. b. 100% of current residents with intermittent catheterization for completion of physician order 5x weekly for 4 weeks,	

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F 690	Continued From page 13 date) of 5/6/19. Resident #68 was assessed with a score of 15 on the BIMS (breif interview for mental status), indicating the resident was cognitively intact. On 05/15/19 at 9:41 AM, Resident #68 was interviewed. During the interview Resident #68 stated that a couple of weeks ago the night shift nurse came into the room to catheterize Resident #68 and was unable to complete the task so the nurse (not identified) left the room and didn't come back. Resident #68 stated that when the day shift nurse came in, Resident #68 complained to her (day shift nurse) so the day shift nurse catheterized Resident #68 and get a lot of urine out. Resident #68 was not able to identify the nurse or nurses that had left her without being catheterized. On 5/15/19 Resident #68's medical record was reviewed. A physician order dated 4/11/19 documented, "in and out cath [catheterization] Q [every] 6 hours. The physician's orders also documented that Resident #68 was on Lasix 40 milligrams twice a day (a diuretic that promotes urination). Resident #68's care plan (dated 3/24/19) also documented Resident #68 was to be catheterized every 6 hours due to neurogenic bladder. Review of Resident #68's treatment administration record (TAR) for the month of May 2019 evidenced that the 6:00 AM documentation for 5/2/19, 5/3/19 and 5/10/19 was blank indicating that catheterization was not performed as ordered by the physician. Nurses notes from 5/1/19 through 5/15/19 were reviewed and did not evidence a concern or	F 690	then review findings in QA. 5) Date of Compliance: 6/5/2019	

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F 690 Continued From page 14 F 690

reason that Resident #68 did not receive catheterization on the above mentioned dates.

On 05/16/19 at 08:38 AM, licensed practical nurse (LPN #6, unit manager) where Resident #68 resides was interviewed. LPN #6 stated that she was aware that Resident #68 unable to be catheterized a couple of weeks ago but said that incident happened on the evening shift. LPN #6 was shown the May TAR with blanks for three night shifts. LPN #6 stated she was unaware of the incident on night shift with the day shift finally catheterizing Resident #68.

On 05/16/19 at 9:13 AM, the above information was brought to the attention of the director of nursing (DON) and nurse consultant. The DON was asked about the purpose of documenting on the TAR. The DON stated that signing the TAR indicates that a task was completed and an undocumented TAR indicates that the task was not performed.

No other information was presented prior to exit conference on 5/16/19.
2. Resident # 7 was admitted to the facility 10/24/18 with diagnoses to include but not limited to: heart failure, high blood pressure, urinary retention, and GERD (gatroespoheagel reflux disease).

The most recent MDS (minimum data set) was a quarterly review dated 2/7/19. Resident # 7 was coded as cognitively intact with a total summary score of 14 out of 15 on the BIMS (breif interview for mental status).

On 5/14/19 at 11:08 a.m., Resident # 7 was observed laying on his bed with the catheter bag

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F 690	Continued From page 15 beside him. When asked why the bag was not hung on the bottom bedframe, he stated "Well, I was getting ready to hang it on my wheelchair over there...there's no where to hang it. I've only had it a couple of days..." On 5/14/19 at 11:15 a.m. LPN (licensed practical nurse) # 3, identified as the charge nurse, was made aware of Resident # 7's catheter bag placement. She stated "No, it should not be on the bed beside him." She stated she would find a place for him to hang it on bottom rung of the bed. During a meeting with facility staff 5/15/19 beginning at 5:15 p.m. the administrator, DON (director of nursing), and corporate nurse consultant were made aware of the above observation. No further information was provided prior to the exit conference.	F 690		
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).	F 725		6/5/19

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F 725	Continued From page 16 §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 individual resident interviews, the group interview, and staff interviews, the facility failed to answer call bells in a prompt manner. Residents complained that call bells either were not responded to, or it took anywhere from a half hour to an hour for a response. The residents cited the evening (3:00 p.m. - 11:00 p.m.) shift as having the slowest response time. The findings were: On 5/14/19 at 11:08 a.m., Resident # 7 was asked if he felt call bells were answered timely. Resident # 7 stated, "Sometimes they come when I ring the bell, sometimes it takes them about an hour or more, and sometimes they don't come at all. Sometimes I have to go looking for them. I don't usually need a whole lot of assistance, so that's a good thing.." On 5/14/19 at 11:35 a.m., Resident #14 was interviewed about quality of life/care in the facility. Resident #14 stated call bell response on her unit	F 725	F 725 1) Residents call bells now are answered promptly. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all staff on answering call bells within 3- 5 mins with resolution promptly following. 4) DON or Designee will randomly audit 3 response times to call bells on each unit across all shifts 5x weekly for 2 weeks, then 3 response times to call bells on each unit across all shifts 3x weekly for 2 weeks then review in QA. 5) Date of Compliance: 6/5/2019	

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F 725	Continued From page 17 was at times very lengthy. Resident #14 stated she had waited up to 45 minutes on the evening shift for response from aides for incontinence care. Resident #14 stated there were evenings that only one Certified Nurse's Aide (CNA) worked on her unit of 30 residents. Resident #14 stated she had limited use of one side of her body and her calls for assistance ranged from needing an out of reach item to incontinence care. Resident #14 stated her lengthy call bell waits ranged from 30 to 45 minutes at times with the slowest response on the evening (3:00 p.m. to 11:00 p.m.) shift. On 5/15/19 at 2:39 p.m., CNA #4, caring for Resident #14 was interviewed about call bell response and staffing. CNA #4 stated call lights were supposed to be answered within 5 minutes and all staff members were expected to respond when a light was activated. CNA #4 stated on most shifts there were two to three CNA's on the 30 resident unit. CNA #4 stated there had been a few shifts when she was the only CNA on the 30-bed unit but nurses and staff from other units came and helped with resident care/requests. On 5/15/19 at 4:30 p.m., CNA #5 that cared for Resident #14 on the evening shift was interviewed about call bell response. CNA #5 stated call bells were supposed to be answered as soon as possible. CNA #5 stated all staff were expected to respond when call bells were heard/seen. On 5/15/19 at 2:48 p.m., the Licensed Practical Nurse (LPN #2) caring for Resident #14 was interviewed about call bell response. LPN #2 stated all staff members were expected to answer call lights and either provide the requested help or	F 725		

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F 725	Continued From page 18	F 725		

get the appropriate person to meet the resident's needs. LPN #2 stated the call light system activated a sounding alarm and visual light above the resident's door.

On 5/15/19 beginning at 10:30 a.m., a group interview was conducted with seven cognitive residents in attendance. The group was asked about call bell response. The Group was unanimous in the response "There is anywhere from slow to no response when you ring your call bell."

The March 2019 staffing schedule for Resident #14's living unit was reviewed. The schedule documented ten shifts during the month with one CNA assigned to the 30-bed unit. Of the ten shifts with one assigned CNA, one was during the evening shift and the other nine were on the night shifts.

On 5/15/19 at 4:35 p.m., the director of nursing (DON) was interviewed about call bell response. The DON stated staff members were expected to respond to call lights within 3 to 5 minutes. The DON stated all staff members were expected to respond to call lights and either provide the requested assistance or promptly get appropriate staff to meet resident needs. The DON stated they did not have a tracking system of call light response times but performed visual audits occasionally to monitor response times. Regarding staffing, the DON stated she preferred to have 2 nurses and 3 CNA's per unit on the day shift and one nurse and 2 to 3 CNA's on the evening and night shifts. The DON stated there had been instances when one CNA was assigned to a 30-bed unit due to call outs. The DON stated when there was only one CNA, nurses assisted

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F 725	Continued From page 19 with direct care and "floater" CNA's from the other units assisted as needed. The DON stated the instances with one CNA usually occurred on the night shift. The DON stated medications were not scheduled on the night shift so nurses were available to help with incontinence care or other care needs.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility	F 761	F 761	6/5/19

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document review, the facility staff failed to ensure drugs and biologicals were properly labeled and stored, on three of four facility units, (100, 400, and 200 units). The facility staff also failed to ensure expired medications were not available for administration.

1. Expired insulin was available for administration on the 100 Unit. Two vials of insulin were not labeled properly on the 400 unit and were available for administration.

2. The facility staff failed to ensure drugs and biologicals were labeled and stored to ensure safe administration on the 200 Unit. A medication cart on the 200 Unit was observed with multiple insulin pens without proper labeling to include patient identification, appropriate temperature control, and discarding of medication per the labels.

The findings include:

1. On 5/15/19 beginning at 7:45 a.m. the medication carts on the 100 unit and 400 unit were inspected. On the 100 unit, the cart inspection was conducted with LPN (licensed practical nurse) # 1. A vial of Novolog (insulin) dated 4/1/19 was observed in the cart. LPN # 1 confirmed the date on the vial and that the vial had been opened. The label from the pharmacy documented the vial was to be discarded 28 days after opening. LPN # 1 stated, "You're right that should have been discarded days ago. I think I last worked this unit about 3 weeks ago, so I really don't have an answer as to why that's still in the cart. I was just called in this morning..."

The medication cart on the 400 unit was then

1) All expired or non dated insulin has been disposed of, and all residents have ordered insulin on hand and accurately labeled. MD made aware of expired medications being on the cart.
2) All residents receiving insulin are at risk.
3) Staff Development Coordinator or designee will educate all licensed nursing staff on proper storage of insulin including removal of expired and proper labeling of medications.
4) DON or Designee will audit 100% of current residents receiving insulin for proper labeling and storage including removal of expired medications, then 50% weekly for 2 weeks, then 20% weekly for 2 weeks then review findings in following QA meeting.
5) Date of Compliance: 6/5/2019

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inspected with LPN # 2. Two vials of insulin were located in the cart without an open date. One vial was Novolog and one vial was Lantus. LPN # 2 stated, "I have no idea when those were opened; I do not think they have been used yet; I think they were just put in the cart as a replacement for the ones that expired." LPN # 2 then took the vials for disposal.

On 5/15/19 at approximately 9:00 a.m., the DON (director of nursing) was asked for the policy on medication storage and labeling. The policy, "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles" was received and reviewed. The policy documented, "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." The attached table to the policy for insulin included both types of insulin and directed "Opened and stored at room temperature 28 days from opening."

During a meeting with facility staff 5/15/19 beginning at 5:15 p.m. the administrator, DON (director of nursing), and corporate nurse consultant were made aware of the above findings.

No further information was provided prior to the exit conference.

2. On 5/15/19 at 8:12 AM, a medication storage cart was observed on the 200 Unit with RN (registered nurse) #1. The medication storage cart was found with a total of 7 insulin pens, which revealed the following:

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A Humalog insulin pen, was observed unopened. The pen did not have a patient's name for identification. The pen had a pharmacy label that documented, 'keep refrigerated until open', the pen was not opened, nor refrigerated. RN #1 did not know who the pen belonged to and did not know how long the pen had been out of refrigeration.

A Levemir flex touch insulin pen was observed. The pen had been opened and used, the pen did not have a label with patient identification. RN #2 stated that she knew who the pen belonged to, that only one resident received this type of insulin. RN #2 stated that the insulin pen should have a label for identification.

A Humalog insulin pen was observed opened, used and labeled with patient identification, and had a label to discard after 28 days, but there was not a date indicating when the pen was opened. RN #2 stated that she did not know how long the pen had been opened, as there was no open date documented.

A Novolog insulin pen was observed opened, used, labeled with patient identification, and had a label to discard after 28 days, but no date was documented when the pen was opened.

A Lantus insulin pen with a resident name, opened, and used had a label to discard after 28 days, but no date was documented indicatiing when the pen was opened.

A Humalin-N insulin pen had been opened and used, had patient identification, and had a label to discard after 14 days of opening; however, there

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was no open date documented indicating when the pen was opened.

A Humalin-N insulin pen without patient information, unopened, had a label that documented to discard after 14 day of opening and to keep refrigerated until open. The pen did not have patient identification, and was not refrigerated per the label.

RN #2 stated that they receive multi packs of insulin pens and they are in a box in the refrigerator and the box is labeled, but the individual pens are not.

A policy was requested on 5/15/19 at approximately 2:30 PM. The policy titled, "Storage and Expiration Dating of medication...", documented the following: "...Facility should ensure that medications and biologicals that (1) have an expired date on the label; (2) have [not] been retained longer than recommended by manufacturer or supplier guidelines...Once any medication or biological package is opened...follow manufacturers/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received...should ensure that medications and biologicals stored in their appropriate temperatures...'

The DON (director of nursing), the corporate nurse and administrator were made aware in a meeting with the survey team on 5/15/19 at

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F 761	Continued From page 24 approximately 4:15 PM. No further information and/or documentation was presented by the exit conference on 5/16/19.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		6/5/19

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F 880	Continued From page 25 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to follow infection control policies for monthly tracking/monitoring of infections in the facility. Facility infections were not thoroughly monitored from January 2019	F 880	F 880 1) Infection control logs are now current and inclusive of all information per policy. 2) All residents are at risk.	

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F 880	Continued From page 26 through April 2019. Tracking information in January 2019 and April 2019 was incomplete. There were no records of facility infections for February and March of 2019. The findings include: The facility infection control policies and tracking information were reviewed on 5/16/19 at 7:47 a.m., accompanied by the registered nurse (RN #2) infection control coordinator and the corporate nursing consultant. Monthly infection tracking logs for January 2019 were incomplete and did not list all facility infections. There were no monthly tracking logs for February 2019 or March 2019. The April 2019 log had incomplete data for 28 out of the 55 infections listed. Missing data included date of onset, type of infection, diagnostic test results, infectious organism and/or treatment. On 5/16/19 at 8:00 a.m., RN #2 and the corporate nursing consultant were interviewed about the missing infection tracking information. The corporate nursing consultant stated there was no tracking information for February/March 2019 and only partial information for January 2019. The nursing consultant stated their previous infection control coordinator moved to another position and someone from another facility was filling in and did not complete the monthly tracking. RN #2 stated she started working in April 2019 and began tracking the infections. RN #2 stated some of the information for April was missing because when she started tracking, some of the residents were already discharged. The facility's infection control policy titled Collection Methods and Monitoring (effective	F 880	3) DON or designee will educate infection control preventionist on policy□s regarding facility infection monitoring including tracking and trending of all occurrences within the center. 4) DON or Designee will audit 100% of May□s infection tracking log for completion and accuracy, then review weekly with infection preventionalist current infections within the center for accuracy with tracking for 4 weeks. 5) Date of Compliance: 6/5/2019	

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F 880	Continued From page 27 8/6/18) documented, "The Center routinely monitors the work environment for infection prevention and control practices, and systematically collects, records, and monitors patient data related to healthcare-acquired infections, including infections prior to and after admission, in order to establish baselines, to assess infection prevention and control measures, and to reduce the risks of transmission or acquisition of infection..." Step 3 of this policy documented, "A licensed nurse routinely assesses patients for the presence of an infection at the time of admission as well as for patients who acquire an infection after being admitted to the Center. The Monthly Infection surveillance form will be utilized, completed and updated daily to facilitate prompt identification of potential infection patterns and trends with the Center. Data obtained will be utilized to develop appropriate interventions to decrease the risk of spreading potential infectious organisms throughout the Center." The policy documented the following information as "essential" for effective analysis of routine surveillance: patient name; room number; location in center; attending physician; site of infection; agent of infection; antibiotic sensitivities; date of admission; date of onset; and the antibiotic report. These findings were reviewed with the administrator and director of nursing during a meeting on 5/16/19 at 12:00 p.m.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 881		6/5/19

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F 881	Continued From page 28 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to implement an antibiotic stewardship program. The facility's documented program regarding protocols and monitoring of antibiotic use was not implemented. The findings include: The antibiotic stewardship policies and tracking information were reviewed on 5/16/19 at 7:47 a.m., accompanied by the registered nurse (RN #2) infection control coordinator and the corporate nursing consultant. There was no evidence of any clinical justification or criteria requirements prior to use of antibiotics for listed infections. Monthly infection tracking logs for January 2019 were incomplete and did not list all facility infections, including use of antibiotics. There were no monthly tracking logs for February 2019 or March 2019. The April 2019 log had incomplete data for 28 out of the 55 infections listed. Missing data included date of onset, type of infection, diagnostic test results, infectious organism and what if any antibiotics were prescribed. On 5/16/19 at 8:00 a.m., the corporate nursing consultant was interviewed about the antibiotic stewardship program. The corporate nursing consultant stated there was no tracking information for February/March 2019 and only	F 881	F 881 1) Antibiotic Stewardship program is now implemented in the center. 2) All residents are at risk 3) DON or designee will educate the infection control preventionalist and licensed nursing staff on the antibiotic stewardship program including the use of McGeer□s criteria for appropriate usage of antibiotic.. 4) DON or Designee will audit 100% of new infections for the utilization of appropriate McGeer□s Criteria to select antibiotic for 4 weeks, then review findings in the following QA meeting. 5) Date of Compliance: 6/5/2019	

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F 881	Continued From page 29 partial information for January 2019. The corporate nursing consultant stated the facility was supposed to use criteria forms (such as McGeer's for urinary tract infections) to determine if antibiotic treatment was appropriate to use. The corporate nursing consultant stated the antibiotic stewardship program had not been implemented in the facility. The corporate nursing consultant stated the criteria forms were supposed to be completed by nursing, sent to the physician and then the physician determined if criteria was met. The nursing consultant stated, "At this point, we do not have that system [antibiotic stewardship] in place." The nursing consultant stated the previous infection control coordinator did not put the system in place and the new coordinator had not implemented the system yet. These findings were reviewed with the administrator and director of nursing during a meeting on 5/16/19 at 12:00 p.m.	F 881		