COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

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9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
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April 19, 2019

Mr. James Anderson, Administrator
Beacon Shores Nursing & Rehabilitation
340 Lynn Shores Drive
Virginia Beach, VA 23452

RE: Beacon Shores Nursing & Rehabilitation
Provider Number 495150

Dear Mr. Anderson:

An unannounced standard survey, ending April 5, 2019, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Ten (10) complaints were investigated during the survey. Seven (7) complaints were substantiated, with deficiencies. Three (3) complaints were substantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was an isolated deficiency that constitutes actual harm that is not immediate jeopardy (S/S of G), as evidenced by the attached CMS-2567L, whereby significant corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Laura Veuhoff, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Center's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

Recommended Remedies

Based on the 'actual harm' deficiencies cited during this survey under 42 CFR §483.25 Quality of Care, this facility has 'no opportunity to correct' prior to the imposition of remedies. Under Subpart F of 42 CFR Part 488 the following remedies may be imposed immediately by the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $103 - $6,188 per day (§488.430, §488.438), effective on the survey ending date.

- Civil money penalties of $2,063 - $20,628 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0151	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATI(	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/1/19 through 4/5/19. Corrections are required to be in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Ten complaints were investigated during survey. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 115 at the time of the survey. The standard survey sample consisted of 39 current Resident reviews; Resident #92, 112, 3, 91, 23, 517, 113, 76, 77, 1, 103, 24, 78, 65, 68, 28, 59, 99, 53, 9, 370, 87, 66, 110, 74, 106, 12, 37, 13, 11, 81, 69, 18, 368, 19, 52, 45, 105, 75, 25, and 268 and 12 closed records; Resident #367, 373, 119, 417, 371, 104, 369, 100, 372, 118, 368, and 117.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: COV 32.1-138 A. Rights and Responsibilities of Patients in Nursing Homes. Cross Reference to F-583. 12 VAC5-371-120 (A) Administration. Cross Reference to F-835. 12 VAC 5-371-140 (A) Cross Reference to F-607, F-609, F-610. 12 VAC 5-371-140-(D.2) Preadmission Screening. Cross Reference to F-645. 12 VAC 5-371-150 (B)(1) Cross Reference To F-550, F-622, F-623, F-625.	F 001	See F-583 See F-835 See F-607, F-609, F-610 See F-645 See F-550, F-622, F-623, F-625	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 4-22-2019

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F 001	Continued From page 1	F 001		
	12 VAC 5-371-150 (D). Resident Rights. Cross Reference to F-582, F-584.		See F-582, F584	
	12 VAC 5-371-220 (A) & (B). Nursing Services. Cross Reference to F-697.		See F-697	
	12 VAC5-371-250 (C) (F) Cross Reference to F-657.		See F-657	
	12 VAC 5-371-220 C.1. Nursing Services. Cross Reference to F686, F758.		See F-686, F-758	
	12 VAC 5-371-250 A., G Resident Assessment. Cross Reference to F-641, F-657.		See F-641, F657	
	12 VAC 5-371-310 B. Diagnostic Services. Cross Reference to F-770.		See F-770	
	12 VAC 5-371-340 (A) Dietary and Food Service Program Cross Reference to F-812.		See F-812	
	12 VAC 5-371-340 (A) Garbage Disposal Cross Reference to F-814.		See F-814	
	12 VAC5-371-370 (F) Maintenance and Housekeeping. Cross Reference to F-924, F-925.		See F-924, F-925	
	12VAC5-371-150 Resident Rights (H). Prior to admission, each nursing facility shall determine if a potential resident is a registered sex offender when the potential resident is anticipated to have a length of stay: Based on record review, staff interview, and review of the facility's policy the facility staff failed to provide the following information: 1. Provide evidence that the facility determines prior to admission if potential residents are		**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. All current residents/responsible parties are being notified of our policy for screening and accommodations of sex offenders. b. Residents/responsible parties will be notified either in person by the Director of Admissions or by letter along with monthly billing statements.	

State of Virginia

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F 001	Continued From page 2 registered as sex offenders (provided if the resident stays longer than 3 days). 2. Provide evidence that each resident and perspective resident with information on how to access the Sex Offender Registry. The facility on request, assist the resident in accessing the Registry. 3. Provide evidence that the facility obtains signed acknowledgement that the resident received this notification. The findings included: On 04/03/19 at approximately 2:00 PM, the Admissions Director was asked to provide the above information from 1 resident's chart prior to being admitted to the facility, how to access the registry and obtaining a signed acknowledgement from Resident and or Resident Responsible party. The Admissions Director was not able to find the above information in the resident's chart. The facility staff was asked to provide a policy related Sex Offender notification. The Admissions Director provided surveyor with a document entitled: Screening and Accommodations for Sex Offenders. The mentioned document was not applicable. On 04/04/19 at approximately 5:30 PM a brief interview was conducted with the Administrator and Director of Nursing they were informed of the above findings. No further information was provided by the facility staff.	F 001	**(2) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The CEO will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. The policy for Screening and Accommodations of Sex Offenders will now be part of our admission agreement. Ensuring that all future residents/responsible parties will be notified of the policy upon admission to the facility. b. The Director of Admissions will also continue to screen each individual prior to admission by searching their name in the State sex offender registry and placing the results in their office file. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Admissions Director will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **Date of Completion: 5/17/19**	

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/01/19 through 04/05/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. Waste Agreement has been revised on 04/23/19 to include a 20 yard roll off dumpster to use as a back-up should our current waste vendor is unable to provide service. b. Sewage agreement was revised on 04/16/19 to include 10 Toilets, 10 handicap Toilets and 5 (2) person hand Wash stations. **(2) How the facility will identify other Residents having the potential to be affected by the same deficient practice.** a. All residents, employees and families could be affected During an emergency event. **(3) What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.** a. Facility will review all agreements once a year or as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 4-29-2019

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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E 015	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an waste and sewage disposal emergency preparedness plan service agreement. The findings included: The facility staff failed to develop an emergency preparedness plan waste and sewage disposal service agreement. During an interview on 4/4/19 at 10:15 A.M. with the administrator, he was asked for documentation of a waste and sewage disposal service agreement. The administrator stated, the facility did not have a waste and sewage disposal service agreement as part of the	E 015	**(4) Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.** a. The CEO will present findings of the agreement review to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **(5) Completion Date: 5/17/19**	

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E 015	Continued From page 2 emergency preparedness plan. The facility staff failed to have an emergency preparedness plan waste and sewage disposal service agreement.	E 015		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037	**(1)How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **a.**Training will be specific for 3-11 7 nurses on what tasks to do during an emergency. Training was completed on 4/25/19 and 4/26/19 with the 3-11 and 11-7 staff. **b.** Training will also be specific for 7-3 staff on what tasks to do during an emergency. Training will be completed on 5/3/2019. **(2)How the facility will identify other Residents having the potential to be affected by the same deficient practice.** **a.** All residents have the potential to be affected. **(3)What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.** **a.** Training to new hires during orientation will begin on 5/8/19 **b.** Yearly nursing training for 7-3, 3-11, &11-7 shifts.	

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E 037	Continued From page 3 hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.	E 037	**(4)Indicate how the facility plans to monitor its performance to make to ensure that solutions are sustained.** a. Sign-in sheets will monitored showing any employee that has missed the training. b. New hires training sheets will be placed in the employees file. c. Changes/Revisions in the emergency plan will be communicated to all employees at the mandatory All Staff Meeting. **(5) Completion Date: 5/17/19**	

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E 037	Continued From page 4 (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 037		

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E 037	Continued From page 5 roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an Initial emergency preparedness plan training . The findings included: The facility staff failed to develop an Initial emergency preparedness plan training. During an interview on 4/4/19 at 11:15 A.M. with the administrator, he was asked for documentation of an Initial emergency preparedness plan training. The administrator stated, the facility had not developed an Initial emergency preparedness plan training program. The facility staff failed to have an Initial	E 037		

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E 037	Continued From page 6 emergency preparedness plan training program.	E 037		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.	E 041	**(1)How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. Fuel Agreement has been revised on 4/18/19 to include delivery of 1,000 gallons of diesel fuel. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents, employees and families could be affected during an emergency event. **(3) What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.** a. Facility will review all agreements once a year or as needed.	

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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E 041	Continued From page 7 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013.	E 041	**(4)Indicate how the facility plans to monitor its performance to make to ensure that solutions are sustained.** a. The CEO will present findings of the agreement review to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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E 041	Continued From page 8 (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an emergency preparedness plan fuel service agreement. The findings included: The facility staff failed to develop an emergency preparedness plan fuel service agreement. During an interview on 4/4/19 at 9:50 A.M. with the administrator, he was asked for documentation of a fuel service agreement. The administrator stated, the facility did not have a fuel service agreement as part of the emergency preparedness plan. The facility staff failed to have an emergency preparedness plan fuel service agreement.	E 041		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/1/19 through 4/5/19.	F 000		

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F 000	Continued From page 9 Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Ten complaints were investigated during survey. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 115 at the time of the survey. The standard survey sample consisted of 39 current Resident reviews; Resident #92, 112, 3, 91, 23, 517, 113, 76, 77, 1, 103, 24, 78, 65, 68, 28, 59, 99, 53, 9, 370, 87, 66, 110, 74, 106, 12, 37, 13, 11, 81, 69, 18, 368, 19, 52, 45, 105, 75, 25, and 268 and 12 closed records; Resident #367, 373, 119, 417, 371, 104, 369, 100, 372, 118, 368, and 117.	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 w'th 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 individua ity. The facility must protect and promote the rights of the resident. §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	F 550	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident # 103 and #113 will receive dignity while dining. Staff will avoiding standing over resident(s) while assisting resident(s) to eat. Staff will provide resident(s) with a plate and silverware while dining. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident who are served meals and/or assisted with meals have the potential to be affected by the deficient practice.	

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F 550	Continued From page 10 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 observations, medical record review, staff interviews and facility document review the facility staff failed to ensure that dignity was maintained for two of 51 residents in the survey sample, Resident #103 and Resident #113. 1. The facility staff failed to ensure Resident #103's dignity was maintained during dining by standing over the resident while providing feeding assistance. 2. The facility staff failed to ensure Resident #113's dignity during dining by removing her plate and utensils and having her eat off of a bare table. The findings included:	F 550	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. All licensed nursed and certified nurses were in-serviced May 3, 2019 by the Director of Nursing or Assistant Director of Nursing on providing dignity while resident(s) are being assisted during dining by avoiding standing over resident(s), engaging them, and providing residents with a plate and silverware while dining. b. A dining audit was done on April 7, 2019 observing all residents dining on 7-3 and 3-11 shifts to ensure the assisted diners were engaged and that staff assisting was seated at eye level. To ensure that all residents had tableware for dining. c. A monitoring tool was developed to observe residents during dining to ensure that staff were seated at eye level and engaging the assisted diner while ensuring all residents were provided with plates and silverware. d. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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F 550	Continued From page 11 1. Resident #103 was a 94 year old admitted to the facility on 3/19/18 with diagnoses to include but not limited to Alzheimer's Disease, Major Depressive Disorder and Falls. Resident #103's most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 3/19/19. Resident #103's Brief Interview for Mental Status (BIMS) indicated that the resident was rarely or never understood, had short and long term memory recall issues and was severely cognitively impaired for daily decision making. On 04/01/19 at 6:25 PM Resident #103 was observed in the locked unit dining room sitting at the table being fed her dinner. CNA (Certified Nursing Assistant) #7 was observed standing over Resident #103 feeding her. There was no chair beside the CNA #7 for her to sit on. CNA #7 was asked why she was standing to feed Resident #103. CNA #7 stated, "We don't have enough chairs and the room is too small." The CNA was asked if she should be feeding resident's while standing. CNA #7 stated, "No we should be sitting down because standing over them makes them feel threatened and rushed." The facility policy titled "Assisting the Impaired Resident with IN-Room Meals" revised 2019 was reviewed and is documented in part, as follows: Purpose: The purpose of this procedure is to provide appropriate support for residents who need assistance with eating. Steps in the Procedure: 3. If you are going to be seated during the feeding position a chair where it will be	F 550	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **(5) Completion Date: 5/17/19**	

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F 550	Continued From page 12 convenient for you and the resident. The facility policy titled "Quality of Life-Dignity" revised August 2019 was reviewed and is documented in part, as follows: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 4. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed. On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared. The Director of Nursing was asked what were her expectations of the staff in regards to feeding residents. The Director of Nursing stated, "I expect them to be seated when they are feeding not standing because it is a dignity issue." Prior to exit no further information was shared. 2. Resident #113 was a 69 year old admitted on 12/21/18 with diagnoses to include but not limited to Traumatic Brain Injury, Mood Disorder and Mental Disorder. Resident #113's most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 3/19/19. Resident #113's Brief Interview for Mental Status (BIMS) indicated that the resident was rarely or never understood, had short and long term memory recall issues and was severely	F 550		

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F 550	Continued From page 13 cognitively impaired for daily decision making. On 04/01/19 at 6:38 PM Resident #113 was observed on the locked unit in the dining room at the table eating her dinner. Resident #113 was observed with no plate or utensils. Cut up pieces of pizza, salad, and a banana was observed on the bare table in front of the resident. Resident #113 was eating with her hands rubbing the pizza on the table like she was dipping it. The resident kept taking the food from the table to her mouth after rubbing it back and forth on the table. CNA #6 was asked if the resident always eats off the table with no utensils and not using a plate. CNA #6 stated, "We just put her food on the table because she throws her plate and the food goes everywhere." CNA #6 also stated, "I only work PRN (as needed) and not always on this floor." On 04/03/19 12:33 PM Resident #113 was observed eating lunch. The resident's food was on a plate in front of her as well as her utensils. She also had a cup on the table with lemonade in it. The resident was not eating off of the table during this meal. On 04/03/19 12:41 PM an interview was conducted with CNA #8 regarding if Resident #113 normally eats her food off of a plate with utensils or eats off the table with no utensils and if she is known to throw her plate and utensils. CNA #8 stated, "She always eats off a plate and she has never thrown her plate on the floor when I have cared for her. I'm here all the time and one of her normal caregivers, we always remove the hot plate from under her regular plate so she won't get burned but her food is always on a plate. CNA #9 was also in the dining area and stated, "I'm here all the time to and I have always	F 550		

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F 550	Continued From page 14 seen her eat her food off a plate never off the table and she has never thrown her plate." The facility policy titled "Quality of Life-Dignity" revised August 2019 was reviewed and is documented in part, as follows: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 4. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed. On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared. The Director of Nursing was asked what were her expectations of the staff in regards to Resident #113 eating off the table. The Director of Nursing stated, "I expect her and all residents to be eating off a plate it's a dignity issue, I'm just shocked right now." Prior to exit no further information was shared.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582		

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F 582	Continued From page 15 nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due	F 582	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident's #100, #104, #417 were not sent a new and complete Advanced Beneficiary Notice (ABN) and a Notice of Medicare Provider Non-Coverage (NOMNC). **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents receiving skilled services have the potential to be affected.	

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F 582	Continued From page 16 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation, the facility staff failed to ensure Notice of Medicare Provider Non-Coverage (NOMNC) and/or Medicare Beneficiary Notices (ABN) in accordance with applicable Federal regulations, were issued to 3 of 3 residents (Resident #100, #104 and #417) in the survey sample. 1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) and Notice of Medicare Provider Non-Coverage (NOMNC) letter to Resident #100. Resident #100 was discharged from skilled services who remained in the facility with Medicare days remaining. 2. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) and Notice of Medicare Provider Non-Coverage (NOMNC) letter to Resident #104. Resident #104 was discharged from skilled services who remained in the facility with Medicare days remaining. 3. The facility staff failed to issue a Notice of Medicare Provider Non-Coverage (NOMNC) letter to Resident #417. Resident #417 was discharged to home from skilled services with Medicare days remaining. The findings included:	F 582	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. Social Worker was given the new ABN letters on 4/3/19. b. Social Worker and Admissions were educated on the policy and procedures of sending notices on 4/5/19 c. Tracking tool was created to ensure the notices are completed and mailed timely. d. Each resident will receive an ABN letter when skilled services are terminating and there are Medicare days remaining alerting the parties that the financial liability under Medicare will no longer be covered and transferred to the resident. e. Social Worker will review tracking sheet weekly for 2 weeks, then monthly for 3 months. f. Performance Improvement Plan and monitoring tool will be reviewed in monthly Quality Assurance Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed.	

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F 582	Continued From page 17 1. Resident #100 was admitted to the nursing facility on 09/21/18 with a diagnosis included but not limited to Epilepsy. The Minimum Data Set (MDS), a quarterly assessment dated 03/12/19 coded the resident with a 01 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. On review of the Beneficiary Notification Checklists provided by the facility to surveyor; Resident #100 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055) or a NOMNC (Notice of Medicare Provider Non-Coverage - form CMS-10123); however no sign copies or documentation were provided. Resident #100 started a Medicare Part A stay on 09/21/18 and the last covered day of this stay was 12/20/18. Resident #100 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN and a NOMNC. Resident #100 had only used 98 days of his Medicare Part A services. The resident's representative was not issued an ABN or NONMC letter. An interview was conducted with the Social Worker (SW) on 04/03/19 at approximately 1:00 p.m. The surveyor reviewed Resident #100's ABN and NOMNC with the SW. The ABN and NOMNC was observed without a representative signature or date. The surveyor asked, "Was the resident's representative informed of the resident's last Medicare Part A stay" she replied "Yes." She said, "I use to make a copy of the	F 582	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Social Services will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **(5) Completion Date: 5/17/19**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 582	Continued From page 18	F 582		

envelope addressed to the resident's representative with a stamp to show it was mailed." The surveyor asked, "Did you get a response back from Resident #100's representative" the SW replied, "No." The surveyor asked, "How do you know the resident's representative received the ABN and NOMNC letter" she replied, "I don't." The SW said, I guess there should be documentation showing the letters were mailed to the resident's representative. The surveyor asked, "What is the purpose for issuing the ABN and NOMNC letters?" The SW said to inform the resident and their representative that the resident will no longer be receiving skilled services and it gives them time to appeal.

A briefing was held on 04/04/19 at approximately 6:05 p.m., with the facility's administration. The surveyor asked, "How do you ensure ABN's or NOMNC's are being delivered when mailed to the resident's representative?" The Administrator stated, "If the forms are being sent via mail, the forms needs to be completed and sent certified; certified mail requires a signature."

2. Resident #104 was admitted to the nursing facility on 02/01/19 with a diagnosis included but not limited to generalized muscle weakness.

The Minimum Data Set (MDS) assessment dated 03/15/19 coded the resident with an 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident with no memory impaired in the skills needed for daily decision making.

On review of the Beneficiary Notification Checklists provided by the facility to surveyor;

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F 582	Continued From page 19 Resident #104 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055) or a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123)); however no sign copies or documentation were provided. Resident #104 started a Medicare Part A stay on 02/01/19 and the last covered day of this stay was 03/15/19. Resident #104 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN and a NOMNC. Resident #104 had only used 44 days of his Medicare Part A services. The resident or representative was not issued an ABN or NONMC letter. An interview was conducted with the Social Worker (SW) on 04/03/19 at approximately 1:00 p.m. The surveyor viewed Resident #104's ABN and NOMNC with the SW. The ABN and NOMNC was observed without a resident or representative signature or date. The surveyor asked, "Was the resident or their representative informed of the resident's last Medicare Part A stay" she replied "Yes." She said, I use to make a copy of the envelope addressed to the resident's representative with a stamp to show it was mailed. The surveyor asked, "Did you get a response back from Resident #104's representative" the SW replied, "No." The surveyor asked, "How do you know the resident's representative received the ABN and NOMNC letter" she replied, "I don't." The SW said, "I guess there should be documentation showing the letters were mailed to the resident's representative." The surveyor asked, "What is the purpose for issuing the ABN and NOMNC	F 582		

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F 582	Continued From page 20 letters?" The SW said to inform the resident and their representative that the resident will no longer be receiving skilled services and it gives them time to appeal. A briefing was held on 04/04/19 at approximately 6:05 p.m., with the facility's administration. The surveyor asked, "How do you ensure ABN's or NOMNC's are being delivered when mailed to the resident's representative?" The Administrator stated, "If the forms are being sent via mail, the forms needs to be completed and sent certified; certified mail requires a signature." 3. Resident #417 was admitted to the nursing facility on 10/24/18 with a diagnosis included but not limited to generalized muscle weakness. The Minimum Data Set (MDS) assessment dated 11/07/18 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated moderate memory impaired in the skills needed for daily decision making. On review of the Beneficiary Notification Checklists provided by the facility to surveyor was noted that Resident #417 was not listed for having been issued a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123); however no sign copies or documentation was provided. Resident #417 started a Medicare Part A stay on 10/24/18, and the last covered day of this stay was 11/19/18. Resident #417 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a NOMNC (CMS-10123). Resident #417 had	F 582		

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F 582	Continued From page 21 only used 23 days of her Medicare Part A services. The resident or their representative was not issued a NONMC letter. An interview was conducted with Social Worker on 04/04/19 at approximately 8:52 a.m., who stated, "I apologize; the NOMNC was not issued to Resident #417." The facility administration was informed of the finding during a briefing on 04/04/19 at approximately 6:05 p.m. The facility did not present any further information about the finding.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident # 69 will receive privacy during the delivery of personal care (wound care). **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who receive personal care have the potential to be affected by the deficient practice.	

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F 583	Continued From page 22 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to protect residents from public view during the delivery of care for one of 51 residents (Resident #69), in the survey sample. The facility staff failed to assure Resident #69's privacy was maintained during wound care. The findings included: Resident #69 was originally admitted to the facility 5/3/11 and readmitted 4/24/15, after admission to a local acute care hospital. The current diagnoses included; stroke, hemiparesis, diabetes, depression and moisture associated skin damage. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/19/19 coded the resident as not completing the Brief Interview for Mental Status (BIMS) therefore the staff interview revealed the resident was with long term and short term memory problems and severely impaired decision making abilities. In section "G" (Physical functioning), the resident was coded as requiring	F 583	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** **a.** All licensed nursed were in-serviced by the Director of Nursing or Assistant Director of Nursing on May 3, 2019 related to providing privacy while resident(s) are receiving personal care (wound care) and the facility policy and procedure. b. A 100% audit has been completed on April 9, 2019 and April 10, 2019 by Nursing Administration of all resident who are receiving wound care on all shifts to ensure the resident was receiving privacy during care. c. A monitoring tool was developed for staff observation of residents during wound care with emphasis placed on privacy ensuring the door is closed, the privacy curtain is pulled, and window coverings are closed. d. This monitoring tool will be utilized by Nursing Administration weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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F 583	Continued From page 23 extensive assistance of 2 people with transfers, extensive assistance of 1 person with bed mobility, dressing, toileting, personal hygiene, eating and bathing. On 4/2/19, at approximately 11:45 a.m., Resident #69's right buttock wound care was observed. The wound care was provided by Licensed Practical Nurse (LPN) #10 assisted by Certified Nursing Assistant (CNA) #13. The resident's lower body was exposed for LPN #10 to provide wound care. The resident resided in the bed closer to the window but the window blinds were not closed prior to beginning care. An automobile was observed passing by the window while the resident's lower body was exposed. LPN #10 pulled the privacy curtain as far as it could be pulled but couldn't close fully around the tract for unknown reasons. The curtain also appeared to be too short, which made it possible for the resident to be viewed by someone visiting or assisting the resident in the A bed. The wound care took approximately 20 minutes to be completed. Immediately after Resident #69 was covered and repositioned an interview was conducted with LPN #1. LPN #1 stated she understood the blinds should have been closed and the privacy curtain fully pulled to maintain privacy. On 4/4/19, at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate quality Assurance Specialist. The Director of Nursing stated the expectation was for staff to maintain the resident's privacy during all care.	F 583	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **(5) Completion Date: 5/17/19**	
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		

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F 584 SS=E	Continued From page 24 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. 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	F 584	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **(2)** Unit 2 lights were not working day one of survey. Electrician was called and repaired the switch on 4/2/19 **(3)** Unit 3a locked unit hallway lights not operating properly. Corrected 4/2/19 **(4)** Hallway between unit 2 and 3a observed to be dark. Corrected 4/2/19 **(5)** Unit 3 storage room was found to have water on the floor with a musty odor. Housekeeping staff mopped and cleaned the storage room on 4/5/19. **(6)** Storage room #2 was found amounts of dirt and debris and dead pests on floor. Housekeeping staff swept up the floor of dirt, debris and pests on 4/5/19. **(7)** Storage room #3 was observed with wheelchair parts on floor. Cluttered with wheelchair and parts. Wheelchairs and parts were removed on 4/5/19. **(8)** Storage room #3's light was not operational. Maintenance replaced light bulb on 4/8/19. **(9)** Unit 3's base boards were missing exposing holes in the walls. Vendors have been called for quotes once received will send them to corporate. Cove base will be replaced by 5/17/19 **(10)** Staff bathroom on unit 3 was missing a toilet top. Maintenance replaced top on 4/5/19. **(11)** Staff bathroom's light switch was not affixed to wall on unit 3. Completed 4/8/19	

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F 584	Continued From page 25 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility staff failed to provide an environment that was safe, clean and homelike. The facility staff failed to provide a safe, clean and homelike environment. The findings included: During the initial tour on 4/1/19 at 4:45 P.M. the north end of Unit II hallway lights were observed to be not operating properly. The Unit II hallway was noted to be dark. During an interview with the Unit II Nursing Manager she stated, the lights had been not operating properly for over six weeks. Residents were observed seated in the hallway. On 4/1/19 at 5:15 P.M. the hallway lights on Unit 3-A Locked Unit, were observed to be not operating properly. The hallway was observed to be dark. Residents were observed to be wandering on the unit. The hallway between Unit II and Unit 3-A was observed to be dark. The hallway was noted to be dark. During the Environmental Tour on 4/5/19 at 9:00 A.M.: The hallway storage room #1 between Unit II and Unit 3-A was observed to have water on the floor. The room had a damp musty odor. Storage room #2 was observed to be cluttered, with excessive amounts of dirt and debris on the floor. Dead roaches were observed on the floor. Storage room #3 was observed to be cluttered with wheel chairs and wheel chair parts. The storage room	F 584	11. Unit 3 dayroom's three drawer night stand, top drawer was off track. Removed 4/24/19 12. Unit 3 dayroom's second three drawer night stand was missing drawer number 2 and third drawer was off track. Removed 4/24/19 13. Room #62 at A/C unit had a 6x4 hole in wall. Corrected 4/25/19. 14. Room #70 had no dresser or night stand. Replaced 4/25/19 15. Activity dayroom on unit 3's A/C unit cover was off with exposed metal knobs. Corrected 4/25/19. 16. Activity dayroom across hallway had dirt and debris on floor. Housekeeping swept room on 4/5/19. 17. Unit 5 shower room had dead pests on floor. Housekeeping removed pests on 4/5/19. 18. Unit 5 shower room with missing tiles at shower with sharp jagged edges. Corrected 4/25/19. 19. Unit 5's tub had an exposed opening 10x18 with exposed dirt and debris. Area was cleaned before maintenance placed door back on opening 4/5/19. 20. Storage room on unit 5 had both clean and dirty linen. Nursing removed all linen from area on 4/5/19. 21. Unit 4's soiled utility room had over bearing amounts of linen with odor. Laundry removed linen and housekeeping cleaned the utility room on 4/5/19. 22. Unit 3 room #60's 3 drawer dresser's third drawer was off track. Corrected 4/25/19	

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F 584	Continued From page 26 light was observed to not be operational. The 3-A Unit base board was noted to be missing exposing holes in the walls. The staff bathroom next to the nursing station was observed to have a commode tank top missing. The tank top was observed lying on the floor broken into several parts. The bathroom light switch was noted to not be affixed to the wall. In the Day Room across from the nursing station a three drawer night stand was observed to have the top drawer off track. A second three drawer night stand was observed to have be missing drawer number two and drawer three was observed to be off track. In Room #62 at the Air Conditioner/Heat Unit a 6 inch by 4 inch hole was observed in the wall. Room #70 which was occupied by a resident was observed to have no dresser or night stand for the resident to store personal belongings. The Activity Day/Dinning Room air conditioner/ heat unit cover was observed to be off with exposed metal knobs. The Activity Day/Dinning Room on the odd number side of the unit was observed to dirt, trash and debris on the floor. Unit 5-A shower room was observed to have dead roaches. There were missing tiles at the shower with sharp jagged edges. The bathroom tub area was observed to have a 10 inch by 18 inch opening with exposed dirt and debris. A room observed to house clean linen was observed to also house dirty soiled linen in the same area. Unit IV utility room was observed to have an over bearing amount of soiled linen with noxious odors coming from the room. Unit 1-in bedroom #60-A the three drawer dresser	F 584	**(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. All resident have the potential to be affected. **(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** 1. 100% audit will be conducted by maintenance on damaged/missing night stands, 3 drawer dressers, walls with holes, A/C's with exposed knobs, missing toilet tops, missing light bulbs, light switches not affixed to walls by 4/26/19 2. Rounding sheet will use used by the Facilities Director/Designee to observe utility rooms, dayrooms and shower rooms. 3. Rounding sheet will be used daily to observe for one week then weekly for two weeks, then monthly for 2 months. 4. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed.	

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F 584	Continued From page 27 was observed to be ill fittings and the third drawer was off track. During an interview on 4/5/19 at 1:30 P.M. with the Administrator he stated, the light were out due to a malfunctioning switch. When asked why it took so long to repair he stated, he could not find an electrician.	F 584	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** 1. The Director of Maintenance and Facilities will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	
F 600 SS=D	Complaint Deficiency Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to ensure one of 51 residents was free from abuse, Resident #91. Facility staff failed to ensure Resident #91 was free from staff to resident abuse that occurred on	F 600	Past noncompliance: no plan of correction required.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28 two separate occasions: one unknown date and on 7/27/18. The findings include: Resident #91 was admitted to the facility on 9/6/17 with diagnoses that included but were not limited to unspecified dementia with behavioral disturbance, arthritis, and high cholesterol. Resident #91's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 3/5/19. Resident #91 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam. Resident #91 was coded as requiring limited assistance from staff with walking, transfers and locomotion. Review of Facility Reported Incidents (FRIs) revealed a FRI on Resident #91 dated 7/29/18 that documented the following: "One employee allege that on two separate occasions that the above resident was tied to a chair with a plastic bag and another time with a sheet. Employees involved were removed from the facility after recurring statements and 100 percent skin assessments and resident interviews were conducted." This FRI was submitted to the OLC (Office of Licensure and Certification) on 7/30/18. The incident date on the top of the FRI was documented as "7/27/18." The five day follow up investigation from the facility dated 8/2/18, documented the following: " ...(Name of Resident #91) was admitted to (Name of facility) on 9/6/17...On July 29, 2018 the DON (Director of Nursing) was notified by (Name of CNA #10) C.N.A. (certified nursing assistant) that she witnessed on two occasions that (Name of	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 600	Continued From page 29 Resident #91) was restrained by a sheet and a plastic bag. On July 27, 2018 (Name of CNA #10) walked into the dining room to find (Name of Resident #91) restrained to the dining room chair with a trash bag. (CNA #10) immediately removed the bag and reported the incident to (Name of LPN (licensed practical nurse) #9. (Name of CNA #10) stated that a co-worker, CNA #2 stated that I did not do it. As per (Name of CNA #10)'s statement she assumed that (Name of CNA #11) was the person who restrained (Name of Resident #91). On July 27, 2018 on the 3-11 shift there were three CNA's (Name of CNA #10, Name of CNA #2, Name of CNA #11 and one LPN, (Name of LPN #5). (Name of CNA #10) did not recall the date of the first incident but witnessed (Name of CNA#12 (another CNA)) restraining (Name of Resident #91) with a sheet to a chair. (Name of CNA #10) reported the incident to (Name of LPN #9)... Actions taken: Virginia Beach Police Department was contacted on July 30th, 2018 and investigated the allegation of abuse and found no injuries on (Name of Resident #91)...A full body assessment was completed on (Name of Resident #91) showing no bruises or skin tears. Care Plan was updated. Social Service Interviewed (Name of Resident #91) and interviewable residents on W-3. 100 % (percent) body assessments were completed on all residents in the facility. 100 % of employees were re-Education (sic) was completed on Resident Abuse. 100 % of employees were re-education (sic) on reporting abuse timely. Monitoring will be conducted by designated staff to complete walking rounds to look for signs of abuse and interview random residents concerning abuse. Delegated staff conducting the rounds will use a	F 600		

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F 600	Continued From page 30	F 600		

form and results of the rounds will be presented to the monthly QAPI. CEO (Chief executive operator) and DON will speak at the next Resident Council Meeting in August concerning resident abuse. Resident council president will invite the local ombudsman to speak at the resident council meeting in October 2018 on Resident Rights and Resident Abuse. Summary: After reviewing witness statements and interviewing employees it is my conclusion that with overwhelming evidence from the eye witness, I substantiate that (Name of Resident #91) was inappropriately restrained with no injuries. Name of (CNA#12) C.N.A will be terminated on August 2, 2018. (Name of CNA #11), C.N.A will be terminated on August 3, 2018. (Name of LPN #9), LPN will be terminated on August 2, 2018. (Name of LPN #5) will be given a written warning on August 3, 2018."

Review of Resident #91's file revealed a thorough investigation was conducted on 7/29/18 by the facility. Abuse was denied by the accused staff members during interviews. A QAPI four point plan of correction was also created on August 6th and implemented. Staff, including unlicensed staff, were re-educated on the abuse policy and improper restraints on August 10th, 2018.

Review of a letter dated 9/11/18 from the Department of Health Professions, revealed that the two accused C.N.A.s were reported to the Board of Nursing.

Review of the termination forms from human resources revealed that CNA #12, CNA #11 and LPN #9 were terminated on 8/2/18 and 8/3/18.

Resident #91's comprehensive care plan was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 600	Continued From page 31 revised on 7/29/18 to reflect the alleged abuse. The following was documented: "(Name of Resident #91) has been allegedly physically abuse (sic) CNA reported the abused (sic)... (Name of Resident #91) will remain safe and will have no repeated incidence of alleged abuse...Abuse Coordinator immediately notified, Follow facility protocol, Notify MD (medical doctor)/RP (responsible party), Document Interventions." CNA #10, #11, #12 and LPN #9 could not be reached for an interview during the survey. On 4/3/19 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #1, the CEO and the abuse coordinator. When asked the process if a resident reported an allegation of abuse by a staff member, ASM #1 stated that he would first remove the staff member from the resident to ensure resident safety, and suspend the staff member pending further investigation. ASM #1 stated that if abuse or injury was founded, he would immediately report abuse to the appropriate state agencies within the two hour time frame. If injury was not found, he would report all allegations of abuse within 24 hours. ASM #1 stated that he would interview the resident involved, other residents on the unit, and staff. On 4/4/19 at 3:30 p.m., further interview was conducted with ASM #1. When asked if he could explain what had happened to Resident #91 on 7/27/18, ASM #1 stated that on 7/29/18 he had received a call from the DON (director of nursing) saying that a CNA (CNA #10) had witnessed (CNA #12) tie the resident to her chair with a bed sheet. ASM #1 stated that he instructed the DON	F 600		

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F 600	Continued From page 32	F 600		

to remove CNA #12 from her assignment and she was suspended pending the investigation. ASM #1 stated that they submitted a FRI within the 24 hour reporting period and also reported this allegation to APS (adult protective services) and the police. ASM #1 stated that they notified Resident #91's RP (responsible party) and the medical doctor. ASM #1 stated that a complete head to toe body assessment was conducted on Resident #91 and no injuries were found. ASM #1 stated that witness statements and skin assessments were conducted on all residents residing on wing 3. ASM #1 stated that witness statements were also obtained from staff members on wing 3. ASM #1 stated that after interviewing CNA #10, it was determined that Resident #91 was restrained on two different occasions, one unknown date with a bed sheet and on 7/27/18 with plastic bags. ASM #1 stated that CNA #10 claimed that she had reported both incidents to the LPNs on the unit at the time of the incidents. ASM #1 stated that the following Monday 7/30/18, the Virginia Beach Police Department came to investigate the incident. ASM #1 stated that Resident #91 was assessed again by the police with no injuries noted. ASM #1 stated that on 8/2/18, a five day follow up to the FRI was faxed to the appropriate state agencies and he concluded with overwhelming evidence that Resident #91 was inappropriately restrained on two different occasions. ASM #1 stated that all staff were re-educated on the abuse policy including reporting abuse in a timely manner. ASM #1 stated that staff were also re-educated on restraints. ASM #1 stated that this education was part of the facility's 4 point plan of correction. ASM #1 stated that the administrative staff were also directed to monitor the units to ensure residents were free from abuse. ASM #1 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 600	Continued From page 33 again that he was not made aware until 7/29/18 (two days) after the last incident. On 4/4/19 at 3:30 p.m., ASM #1 was made aware of the above concerns. Past Non-Compliance (PNC) COMPLAINT DEFICIENCY	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive	F 604		

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F 604	Continued From page 34 alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to ensure one of 51 residents were free from inappropriate physical restraints, Resident #91. Facility staff failed to ensure Resident #91 was free from physical restraints on two separate occasions (one unknown date) and 7/27/18. The findings include: Resident #91 was admitted to the facility on 9/6/17 with diagnoses that included but were not limited to unspecified dementia with behavioral disturbance, arthritis, and high cholesterol. Resident #91's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 3/5/19. Resident #91 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam. Resident #91 was coded as requiring limited assistance from staff with walking, transfers and locomotion. Review of Facility Reported Incidents (FRIs) revealed a FRI on Resident #91 dated 7/29/18 that documented the following: "One employee allege that on two separate occasions that the above resident was tied to a chair with a plastic bag and another time with a sheet. Employees involved were removed from the facility after recurring statements and 100 percent skin	F 604	Past noncompliance: no plan of correction required.	

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F 604	Continued From page 35 assessments and resident interviews were conducted." This FRI was submitted to the OLC (Office of Licensure and Certification) on 7/30/18. The incident date on the top of the FRI was documented as "7/27/18." The five day follow up investigation from the facility dated 8/2/18, documented the following: " ...(Name of Resident #91) was admitted to (Name of facility) on 9/6/17...On July 29, 2018 the DON (Director of Nursing) was notified by (Name of CNA #10) C.N.A. (certified nursing assistant) that she witnessed on two occasions that (Name of Resident #91) was restrained by a sheet and a plastic bag. On July 27, 2018 (Name of CNA #10) walked into the dining room to find (Name of Resident #91) restrained to the dining room chair with a trash bag. (CNA #10) immediately removed the bag and reported the incident to (Name of LPN (licensed practical nurse) #9. (Name of CNA #10) stated that a co-worker, CNA #2 stated that I did not do it. As per (Name of CNA #10)'s statement she assumed that (Name of CNA #11) was the person who restrained (Name of Resident #91). On July 27, 2018 on the 3-11 shift there were three CNA's (Name of CNA #10, Name of CNA #2, Name of CNA #11 and one LPN, (Name of LPN #5). (Name of CNA #10) did not recall the date of the first incident but witnessed (Name of CNA#12 (another CNA)) restraining (Name of Resident #91) with a sheet to a chair. (Name of CNA #10) reported the incident to (Name of LPN #9)... Actions taken: Virginia Beach Police Department was contacted on July 30th, 2018 and investigated the allegation of abuse and found no injuries on (Name of Resident #91)...A full body assessment was completed on (Name of	F 604		

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 604	Continued From page 36 Resident #91) showing no bruises or skin tears. Care Plan was updated. Social Service Interviewed (Name of Resident #91) and interviewable residents on W-3. 100 % (percent) body assessments were completed on all residents in the facility. 100 % of employees were re-Education (sic) was completed on Resident Abuse. 100 % of employees were re-education (sic) on reporting abuse timely. Monitoring will be conducted by designated staff to complete walking rounds to look for signs of abuse and interview random residents concerning abuse. Delegated staff conducting the rounds will use a form and results of the rounds will be presented to the monthly QAPI. CEO (Chief executive operator) and DON will speak at the next Resident Council Meeting in August concerning resident abuse. Resident council president will invite the local ombudsman to speak at the resident council meeting in October 2018 on Resident Rights and Resident Abuse. Summary: After reviewing witness statements and interviewing employees it is my conclusion that with overwhelming evidence from the eye witness, I substantiate that (Name of Resident #91) was inappropriately restrained with no injuries. Name of (CNA#12) C.N.A will be terminated on August 2, 2018. (Name of CNA #11), C.N.A will be terminated on August 3, 2018. (Name of LPN #9), LPN will be terminated on August 2, 2018. (Name of LPN #5) will be given a written warning on August 3, 2018." Review of Resident #91's file revealed a thorough investigation was conducted on 7/29/18 by the facility. Abuse was denied by the accused staff members during interviews. A QAPI four point plan of correction was also created on August 6th (2018) and implemented. Staff, including	F 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 604	Continued From page 37 unlicensed staff, were re-educated on the abuse policy and improper restraints on August 10th, 2018. Review of a letter dated 9/11/18 from the Department of Health Professions, revealed that the two accused C.N.As were reported to the Board of Nursing. Review of the termination forms from human resources revealed that CNA #12, CNA #11 and LPN #9 were terminated on 8/2/18 and 8/3/18. Resident #91's comprehensive care plan was revised on 7/29/18 to reflect the alleged abuse. The following was documented: "(Name of Resident #91) has been allegedly physically abuse (sic) CNA reported the abused (sic)... (Name of Resident #91) will remain safe and will have no repeated incidence of alleged abuse...Abuse Coordinator immediately notified, Follow facility protocol, Notify MD (medical doctor)/RP (responsible party), Document Interventions." CNA #10, #11, #12 and LPN #9 could not be reached for an interview during the survey. On 4/4/19 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #3, a random nurse. When asked if restraints were allowed in the facility, LPN #3 stated that restraints were not allowed in the facility. When asked of restraining a resident to a chair with bed sheets or plastic bags was abuse, LPN #2 stated, "Yes, that is considered abuse." When asked her process if it was reported to her that a resident was inappropriately restrained with a bed sheet or plastic bag, LPN #2 stated that she would remove	F 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 604	Continued From page 38 the resident from the situation and report right away to the CEO (Chief Executive Officer). On 4/4/19 at 3:30 p.m., an interview was conducted with ASM #1. When asked if he could explain what had happened to Resident #91 on 7/27/18, ASM #1 stated that on 7/29/18 he had received a call from the DON (director of nursing) saying that a CNA (CNA #10) had witnessed (CNA #12) tie the resident to her chair with a bed sheet. ASM #1 stated that he instructed the DON to remove CNA #12 from her assignment and she was suspended pending the investigation. ASM #1 stated that they submitted a FRI within the 24 hour reporting period and also reported this allegation to APS (adult protective services) and the police. ASM #1 stated that they notified Resident #91's RP (responsible party) and the medical doctor. ASM #1 stated that a complete head to toe body assessment was conducted on Resident #91 and no injuries were found. ASM #1 stated that witness statements and skin assessments were conducted on all residents residing on wing 3. ASM #1 stated that witness statements were also obtained from staff members on wing 3. ASM #1 stated that after interviewing CNA #10, it was determined that Resident #91 was restrained on two different occasions, one unknown date with a bed sheet and on 7/27/18 with plastic bags. ASM #1 stated that CNA #10 claimed that she had reported both incidents to the LPNs on the unit at the time of the incidents. ASM #1 stated that the following Monday 7/30/18, the Virginia Beach Police Department came to investigate the incident. ASM #1 stated that Resident #91 was assessed again by the police with no injuries noted. ASM #1 stated that on 8/2/18, a five day follow up to the FRI was faxed to the appropriate state agencies	F 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 604	Continued From page 39 and he concluded with overwhelming evidence that Resident #91 was inappropriately restrained on two different occasions. ASM #1 stated that all staff were re-educated on the abuse policy including reporting abuse in a timely manner. ASM #1 stated that staff were also re-educated on restraints. ASM #1 stated that this education was part of the facility's 4 point plan of correction. ASM #1 stated that the administrative staff were also directed to monitor the units to ensure residents were free from abuse. ASM #1 stated again that he was not made aware until 7/29/18 (two days) after the last incident. On 4/4/19 at 3:30 p.m. ASM #1 was made aware of the above concerns. Facility policy titled, "Use of Restraints," documents in part, the following: "Restraints should only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls." Past Non-Compliance (PNC) Complaint Deficiency.	F 604		
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,	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 40 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that facility staff failed to implement abuse policies and thoroughly investigate and report an allegation of abuse to the facility administrator and to the appropriate state agencies for three of 51 residents in the survey sample, Residents #91, #66 and #103. 1. For Resident #91, facility staff failed to implement abuse policies and report an allegation of abuse in a timely manner to the facility administrator on two separate occasions; one unknown date, and on 7/27/18. 2. For Resident #66, facility staff failed to implement abuse policies and thoroughly investigate and report an allegation of sexual abuse to the appropriate state agencies on 5/15/18. 3. The facility staff failed to to implement its "Abuse Prevention/Reporting Policy and Procedure" and their "Abuse Investigation and Reporting Policy" to include reporting and through investigation for a serious bodily injury observed on 1/20/19 for Resident #103. The findings include: 1. Resident #91 was admitted to the facility on	F 607	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident's #91, #66 and #103 were affected by this practice. b. No further allegations of abuse for resident's #91, #66, and #103 **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected. **(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. The abuse coordinator (CEO) was re-in-serviced on the Abuse Prevention/ Reporting Policy and procedure and use of restraints on 4/5/19 by Regional Quality Specialist. b. Tracking tool was created to track abuse allegations. c. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed. d. All staff will be educated by the Assistant Director of Nursing on the Abuse Prevention/Reporting Policy and procedures. This education will be completed on 5/3/2019.	

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F 607	Continued From page 41 9/6/17 with diagnoses that included but were not limited to unspecified dementia with behavioral disturbance, arthritis, and high cholesterol. Resident #91's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 3/5/19. Resident #91 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam. Resident #91 was coded as requiring limited assistance from staff with walking, transfers and locomotion. Review of Facility Reported Incidents (FRIs) revealed a FRI on Resident #91 dated 7/29/18 that documented the following: "One employee allege that on two separate occasions that the above resident was tied to a chair with a plastic bag and another time with a sheet. Employees involved were removed from the facility after recurring statements and 100 percent skin assessments and resident interviews were conducted." This FRI was submitted to the OLC (Office of Licensure and Certification) on 7/30/18. The incident date on the top of the FRI was documented as "7/27/18." The five day follow up investigation from the facility dated 8/2/18, documented the following: " ...(Name of Resident #91) was admitted to (Name of facility) on 9/6/17...On July 29, 2018 the DON (Director of Nursing) was notified by (Name of CNA #10) C.N.A. (certified nursing assistant) that she witnessed on two occasions that (Name of Resident #91) was restrained by a sheet and a plastic bag. On July 27, 2018 (Name of CNA #10) walked into the dining room to find (Name of Resident #91) restrained to the dining room chair with a trash bag. (CNA #10) immediately removed the bag and reported the incident to (Name of	F 607	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The CEO will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 607	Continued From page 42 LPN (licensed practical nurse) #9. (Name of CNA #10) stated that a co-worker, CNA #2 stated that I did not do it. As per (Name of CNA #10)'s statement she assumed that (Name of CNA #11) was the person who restrained (Name of Resident #91). On July 27, 2018 on the 3-11 shift there were three CNA's (Name of CNA #10, Name of CNA #2, Name of CNA #11 and one LPN, (Name of LPN #5). (Name of CNA #10) did not recall the date of the first incident but witnessed (Name of CNA#12 (another CNA)) restraining (Name of Resident #91) with a sheet to a chair. (Name of CNA #10) reported the incident to (Name of LPN #9)... Actions taken: Virginia Beach Police Department was contacted on July 30th, 2018 and investigated the allegation of abuse and found no injuries on (Name of Resident #91)...A full body assessment was completed on (Name of Resident #91) showing no bruises or skin tears. Care Plan was updated. Social Service Interviewed (Name of Resident #91) and interviewable residents on W-3. 100 % (percent) body assessments were completed on all residents in the facility. 100 % of employees were re-Education (sic) was completed on Resident Abuse. 100 % of employees were re-education (sic) on reporting abuse timely. Monitoring will be conducted by designated staff to complete walking rounds to look for signs of abuse and interview random residents concerning abuse. Delegated staff conducting the rounds will use a form and results of the rounds will be presented to the monthly QAPI. CEO (Chief executive operator) and DON will speak at the next Resident Council Meeting in August concerning resident abuse. Resident council president will invite the local ombudsman to speak at the	F 607		

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F 607	Continued From page 43 resident council meeting in October 2018 on Resident Rights and Resident Abuse. Summary: After reviewing witness statements and interviewing employees it is my conclusion that with overwhelming evidence from the eye witness, I substantiate that (Name of Resident #91) was inappropriately restrained with no injuries. Name of (CNA#12) C.N.A will be terminated on August 2, 2018. (Name of CNA #11), C.N.A will be terminated on August 3, 2018. (Name of LPN #9), LPN will be terminated on August 2, 2018. (Name of LPN #5) will be given a written warning on August 3, 2018." Review of Resident #91's file revealed a thorough investigation was conducted on 7/29/18 by the facility. Abuse was denied by the accused staff members during interviews. A QAPI four point plan of correction was also created on August 6th and implemented. Staff, including unlicensed staff, were re-educated on the abuse policy and improper restraints on August 10th, 2018. Review of a letter dated 9/11/18 from the Department of Health Professions, revealed that the two accused C.N.As were reported to the Board of Nursing. Review of the termination forms from human resources revealed that CNA #12, CNA #11 and LPN #9 were terminated on 8/2/18 and 8/3/18. Resident #91's comprehensive care plan was revised on 7/29/18 to reflect the alleged abuse. The following was documented: "(Name of Resident #91) has been allegedly physically abuse (sic) CNA reported the abused (sic)... (Name of Resident #91) will remain safe and will have no repeated incidence of alleged	F 607		

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F 607	Continued From page 44 abuse...Abuse Coordinator immediately notified, Follow facility protocol, Notify MD (medical doctor)/RP (responsible party), Document Interventions." CNA #10, #11, #12 and LPN #9 could not be reached for an interview during the survey. On 4/3/19 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #1, the CEO and the abuse coordinator. When asked the process if a resident reported an allegation of abuse by a staff member, ASM #1 stated that he would first remove the staff member from the resident to ensure resident safety, and suspend the staff member pending further investigation. ASM #1 stated that if abuse or injury was founded, he would immediately report abuse to the appropriate state agencies within the two hour time frame. If injury was not found, he would report all allegations of abuse within 24 hours. ASM #1 stated that he would interview the resident involved and other residents on the unit if the resident was not cognitively intact. ASM #1 stated that the resident involved would also be assessed for injuries. On 4/4/19 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #3, a random nurse. When asked if restraints were allowed in the facility, LPN #3 stated that restraints were not allowed in the facility. When asked of restraining a resident to a chair with bed sheets or plastic bags was abuse, LPN #2 stated, "Yes, that is considered abuse." When asked her process if it was reported to her that a resident was inappropriately restrained with a bed sheet or plastic bag, LPN #2 stated that she would remove the resident from the situation and report right	F 607		

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F 607	Continued From page 45 away to the CEO (Chief Executive Officer). On 4/4/19 at 3:30 p.m., an interview was conducted with ASM #1. When asked if he could explain what had happened to Resident #91 on 7/27/18, ASM #1 stated that on 7/29/18 he had received a call from the DON (director of nursing) saying that a CNA (CNA #10) had witnessed (CNA #12) tie the resident to her chair with a bed sheet. ASM #1 stated that he instructed the DON to remove CNA #12 from her assignment and she was suspended pending the investigation. ASM #1 stated that they submitted a FRI within the 24 hour reporting period and also reported this allegation to APS (adult protective services) and the police. ASM #1 stated that they notified Resident #91's RP (responsible party) and the medical doctor. ASM #1 stated that a complete head to toe body assessment was conducted on Resident #91 and no injuries were found. ASM #1 stated that witness statements and skin assessments were conducted on all residents residing on wing 3. ASM #1 stated that witness statements were also obtained from staff members on wing 3. ASM #1 stated that after interviewing CNA #10, it was determined that Resident #91 was restrained on two different occasions, one unknown date with a bed sheet and on 7/27/18 with plastic bags. ASM #1 stated that CNA #10 claimed that she had reported both incidents to the LPNs on the unit at the time of the incidents. ASM #1 stated that the following Monday 7/30/18, the Virginia Beach Police Department came to investigate the incident. ASM #1 stated that Resident #91 was assessed again by the police with no injuries noted. ASM #1 stated that on 8/2/18, a five day follow up to the FRI was faxed to the appropriate state agencies and he concluded with overwhelming evidence	F 607		

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F 607	Continued From page 46 that Resident #91 was inappropriately restrained on two different occasions. ASM #1 stated that all staff were re-educated on the abuse policy including reporting abuse in a timely manner. ASM #1 stated that staff were also re-educated on restraints. ASM #1 stated that this education was part of the facility's 4 point plan of correction. ASM #1 stated that the administrative staff were also directed to monitor the units to ensure residents were free from abuse. ASM #1 stated again that he was not made aware until 7/29/18 (two days) after the last incident. On 4/3/19 at 2:35 p.m., ASM #1 was made aware of the above concern. 2. For Resident #66, facility staff failed to implement abuse policies and thoroughly investigate and report an allegation of sexual abuse to the appropriate state agencies on 5/15/18. Resident #66 was admitted to the facility on 10/11/13 and readmitted on 7/24/14 with diagnoses that included but were not limited to major depressive disorder, type two diabetes mellitus, and cerebrovascular disease. Resident #66's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/19/19. Resident #66 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded as requiring one person physical assist with bathing. On 3/20/19 a complaint was submitted to the OLC (Office of Licensure and Certification)	F 607		

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F 607	Continued From page 47 regarding sexual abuse between a CNA (certified nursing assistant) and Resident #66. On 4/2/19 at 10:16 a.m., an interview was conducted with Resident #66. Resident #66 denied any abuse from staff members. Resident #66 declined further interview and asked this writer to leave her room. Review of Resident #66's clinical record revealed that she had filed a grievance with the social worker on 5/15/18. The following was documented by the social worker: "Describe concern in detail: CNA(certified nursing assistant) (Name of CNA #16) made her uncomfortable during shower. said (sic) "I'll wash your back if you wash my back." Was not using washcloth to wash her back-did not want him to use bare hands. Staff member assigned responsibility for the investigation: (Name of CEO (Chief Executive Officer)), Assigned by SS (Social Services). Date assigned: 5/15/18. Findings of investigation: Spoke to (Name of CNA #16) at 3:00 PM on 5-16-18 concerning the care given during a shower to resident. He stated that he did shower resident and was using gloves. He denied saying "I'll wash your back if you wash my back."' Plan to resolve complaint/grievance: (Name of CNA #16) will use a washcloth and gloves during care. 2 Warned that comments as described would not be tolerated." Results of actions taken: Spoke with (Name of Resident #66) and told her that (Name of CNA #16) will use gloves and washcloth during care." There was no evidence in the clinical record that all residents on the unit were interviewed regarding CNA #16. There was no evidence that the CNA #16 was suspended pending	F 607		

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F 607	Continued From page 48 investigation. Review of the staff sheets dated 5/2018 through 6/2018 revealed that CNA #16 was reassigned after this incident to a different unit. Review of the staff sheets from the last three months revealed that CNA #16 identified had not been working with Resident #66. Review of the CNA #16's employee file revealed that the employee had no previous history of any barrier crimes. Review of Resident #66's comprehensive care plan dated 2/21/19 failed to evidence this allegation of sexual abuse. On 4/3/19 at 1:26 p.m., an interview was conducted with OSM (other staff member) #1, the social worker. When asked how she would take the above statement made by the CNA, OSM #1 stated,"It made my skin crawl." When asked if she would consider that statement abuse, OSM #1 stated, "Yes, I would consider that sexual abuse." OSM #1 stated that she reported this allegation to the administrator. On 4/3/19 at 2:25 p.m., an interview was conducted with CNA (certified nursing assistant) #16, the CNA identified in the grievance. When asked what he could recall about the incident with Resident #66, CNA #16 stated that he was helping her with her shower and that the resident claimed he was not wearing any gloves while he was assisting. CNA #16 stated that he was wearing gloves but apologized to the resident anyway. CNA #16 stated that Resident #66 accepted his apology and assured her that it	F 607		

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F 607	Continued From page 49 wouldn't happen again. CNA #16 stated that he is not allowed to be assigned to her and that he was moved from her care. CNA #16 stated that he did not recall making the above statement. CNA #16 stated that he was not suspended. CNA #16 stated that ASM #1 had talked to him and he had apologized to the resident the same day. On 4/3/19 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #1, the CEO and the abuse coordinator. When asked the process if a resident reported an allegation of abuse by a staff member, ASM #1 stated that he would first remove the staff member from the resident to ensure resident safety, and suspend the staff member pending further investigation. ASM #1 stated that if abuse or injury was founded, he would immediately report abuse to the appropriate state agencies within the two hour time frame. If injury was not found, he would report all allegations of abuse within 24 hours. ASM #1 stated that he would interview the resident involved and other residents on the unit if the resident was not cognitively intact. ASM #1 stated that the resident involved would also be assessed for injuries. When asked what he could remember about Resident #66 and the male CNA, ASM #1 stated that he thought the CNA grabbed her. ASM #1 could not recall the CNA making an inappropriate statement. This writer let ASM #1 read the grievance report. ASM #1 then stated, "He denied saying that." ASM #1 stated that he did not report this allegation to the appropriate state agencies. ASM #1 stated that he moved the CNA to another unit. When asked if the statement made by the CNA was inappropriate, ASM #1 stated that it was. When asked if the above comment was abuse, ASM #1 stated that it was	F 607		

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F 607	Continued From page 50 verbal abuse and that it should have been reported. ASM #1 stated that he did not conduct an investigation ASM #1 stated that the CNA continued to work with residents after the reported allegation made by Resident #66. On 4/3/19 at 2:35 p.m., ASM #1 was made aware of the above concerns. 3. The facility staff failed to to implement its "Abuse Prevention/Reporting Policy and Procedure" and their "Abuse Investigation and Reporting Policy" to include reporting and through investigation for a serious bodily injury observed on 1/20/19 for Resident #103. Resident #103 was a 94 year old admitted to the facility on 3/19/18 with diagnoses to include but not limited to Alzheimer's Disease, Major Depressive Disorder and Falls. Resident #103's most recent Minimum Data Set (MDS) assessment was an Annual assessment with an Assessment Reference Date (ARD) of 3/19/19. Resident #103's Brief Interview for Mental Status (BIMS) indicated that the resident was rarely or never understood, had short and long term memory recall issues and was severely cognitively impaired for daily decision making. Resident #103's Nurse's Notes were reviewed and are documented in part, as follows: 1/20/19 8 AM: Notified by CNA (Certified Nursing Assistant) resident have bruising to R (right) shoulder when she touched her arm. Pt. (patient) express pain. Pt. assess right shoulder bruising , red in color, swelling and warm to touch. Pt. express pain with touch stimuli. MD (medical doctor) notified new order X-ray right shoulder.	F 607		

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F 607	Continued From page 51 RP (responsible party) made aware. Tylenol 2 tabs 650 mg(milligrams) given for pain. Mobilex notified, awaiting x-ray tech. 1/20/19 12 PM X-ray tech rendered care. Awaiting x-ray results. 1/20/19 3:30 PM: MD made aware of x-ray results. N.O. (new order) send to ER (emergency room) for evaluation and treatment. RP made aware. Resident #103's physician orders were reviewed and are documented in part, as follows: 1/20/19: Medication Order-Right shoulder X-ray two views. Indication/Diagnosis- Right shoulder bruise, swelling, pain. 1/20/19: Medication Order-Send to ER for evaluation and treatment. Indication/Diagnosis-Distal right clavicle fracture. Resident #103's Radiology Report dated 1/20/19 at 12:52 PM was reviewed and is documented in part, as follows: Results: There is a displaced fracture of the distal right clavicle. No significant callus formation noted and the fracture appears recent. Conclusion: Displaced distal right clavicle fracture. Fax time stamp at top of the radiology report to the facility was 1/20/19 at 12:55 PM.	F 607		

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F 607	Continued From page 52 Resident #103's Emergency Room documentation dated 1/20/19 was reviewed and is documented in part, as follows: Diagnosis: Closed displaced fracture of acromial end of right clavicle. ED (Emergency Department) Notes/Significant Events Notes: Pt. (patient) arrived by rescue from Name (facility) for a broken RIGHT clavicle per x-rays; staff was unable to tell rescue what caused fracture. ED Attending Supervision Note: 93 year old female sent from nursing home for broken clavicle. Altered at baseline per family. Trauma unwitnessed, unknown if fell. Resident#103's Facility Reported Incident (FRI) dated 1/21/19 was reviewed and is documented in part, as follows: Report date: 1/21/2019 Incident date: 1/20/2019 Injuries: Yes, Fracture to right clavicle. Incident Type: Injury of unknown origin. Describe incident, including location,and action taken: Right shoulder noted with bruising, swelling and painful to touch by CNA who reported her observation to LPN (Licensed Practical Nurse). Physician was notified and ordered an x-ray. results of x-ray obtained showing a right clavicle fracture. Orders to send resident to ER and returned to facility at 11:45 PM. If applicable, date notification provided to: Responsible Party: 1/20/19 Physician: 1/20/19	F 607		

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F 607	Continued From page 53 APS(Adult Protective Services): 1/21/19 Fax time stamp at top of the FRI report to the Office of Licensure and Certification was 1/21/19 at 16:25(4:25) PM. The facility policy titled "Abuse Investigation and Reporting" last revised 7/2017 was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility. b. The local/State Ombudsman. d. Adult Protective Services (where state law provides jurisdiction in long-term care). 2. An alleged violation of abuse, neglect, exploitation, or mistreatment, (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. The facility policy titled "Abuse	F 607		

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F 607	Continued From page 54 Prevention/Reporting Policy and Procedure" updated 5/8/18 was reviewed and is documented in part, as follows: Investigation: 7. If the crime/abuse involves serious bodily injury including criminal sexual abuse to the resident it will be reported immediately but no later than 2 hours after forming the suspicion to the local authorities and the State Department of Health. On 4/2/19 at approximately 4:15 PM an interview was conducted with the Administrator regarding Resident #103's serious bodily injury of unknown origin that occurred on 1/20/19 but not reported until 1/21/19. The Administrator stated, "The injury should have been reported within 2 hours of the facility being made aware that the resident had a fracture." The facility's 5 Day Investigation for Resident #103's serious bodily injury of unknown origin dated 1/23/19 was reviewed and is documented in part, as follows: Investigation: On 1/20/19 all unit employees on the 7-3, 3-11, and 11-7 shift were interviewed and completed written statements. On 4/03/19 04:26 PM the Director of Nursing was asked for the staff statements that were obtained during the investigation of Resident #103's right clavicle fracture of unknown origin on 1/20/19. On 04/03/19 02:31 PM the Director of Nursing was asked she was able to obtain the staff	F 607		

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F 607	Continued From page 55 statements. The Director of Nursing stated, "No we don't have them, the Administrator said they were done but we can't find them." Summary: After reviewing all witness statements and receiving the resident interview by Social Services I conclude that the injury of unknown injury was as a result of Name (Resident #103) falling between the hours of 11:00 PM to 7:00 AM. On 4/03/19 05:00 PM an interview was conducted with the Administrator regarding his investigation of Resident #103's fractured clavicle to include the staff statements and who was instructed to update the resident's plan of care to include non-skid socks. The Administrator stated, "I can't find the staff statements that were done with the initial investigation, they (the staff members) are all still here I can have them rewrite them. I told Name (MDS Coordinator) to update the care plan regarding the non skid socks." The facility policy titled "Abuse Investigation and Reporting" last revised 7/2017 was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: g. Interview staff members (on all shifts) who have had contact with the resident during the	F 607		

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F 607	Continued From page 56 period of the alleged incident. 2. The following guidelines will be used when conducting interviews: d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. The facility policy titled "Abuse Prevention/Reporting Policy and Procedure" updated 5/8/18 was reviewed and is documented in part, as follows: Investigation: 9. The Administrator and the D.O.N. (Director of Nursing) will conduct a comprehensive investigation of any and ALL allegations of abuse/neglect or misappropriation of resident property in accordance with state law, federal regulation and The Patient Protection and Affordable Care Act (Elder Justice Act). 10. The investigating team will interview all parties concerned: witnesses, staff, the accused and the alleged victim as appropriate and obtain signed statements as possible. On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared. Prior to exit no further information was shared.	F 607		
F 609 SS=D	Complaint Deficiency. Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		

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F 609	Continued From page 57 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to report an allegation of abuse to the facility administrator and to the appropriate state agencies in a timely manner for three of 51 residents in the survey sample, Residents #91, #66 and #103.	F 609	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident's #91, #66, #103 did not report an allegation of abuse timely. b. Resident #66 did not report an allegation of sexual abuse to appropriate state agencies. c. Facility Reported Incident (FRI) will be sent for resident #66. Completed on 5/2/19 **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected. **(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. The abuse coordinator (CEO) was re-in-serviced on the Abuse Prevention/ Reporting Policy and procedure and use of restraints on 4/5/19 by Regional Quality Specialist. b. Tracking tool was created to track abuse allegations. c. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed	

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F 609	Continued From page 58 1. For Resident #91, facility staff failed to report an allegation of abuse in a timely manner to the facility administrator on two separate occasions; one unknown date, and on 7/27/18. 2. For Resident #66, facility staff failed to report an allegation of sexual abuse to the appropriate state agencies on 5/15/18. 3. The facility staff failed to report an injury of unknown origin that resulted in serious bodily injury within 2 hours to the appropriate State Survey Agencies on 1/20/19 for Resident #103. The findings include: 1. Resident #91 was admitted to the facility on 9/6/17 with diagnoses that included but were not limited to unspecified dementia with behavioral disturbance, arthritis, and high cholesterol. Resident #91's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 3/5/19. Resident #91 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam. Resident #91 was coded as requiring limited assistance from staff with walking, transfers and locomotion. Review of Facility Reported Incidents (FRIs) revealed a FRI on Resident #91 dated 7/29/18 that documented the following: "One employee allege that on two separate occasions that the above resident was tied to a chair with a plastic bag and another time with a sheet. Employees involved were removed from the facility after recurring statements and 100 percent skin assessments and resident interviews were conducted." This FRI was submitted to the OLC	F 609	d. All current staff will be educated by the Assistant Director of Nursing on the Abuse Prevention/Reporting Policy. The education will be completed on 4/26/19. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The CEO will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 609	Continued From page 59 (Office of Licensure and Certification) on 7/30/18. The incident date on the top of the FRI was documented as "7/27/18." The five day follow up investigation from the facility dated 8/2/18, documented the following: " ...(Name of Resident #91) was admitted to (Name of facility) on 9/6/17...On July 29, 2018 the DON (Director of Nursing) was notified by (Name of CNA #10) C.N.A. (certified nursing assistant) that she witnessed on two occasions that (Name of Resident #91) was restrained by a sheet and a plastic bag. On July 27, 2018 (Name of CNA #10) walked into the dining room to find (Name of Resident #91) restrained to the dining room chair with a trash bag. (CNA #10) immediately removed the bag and reported the incident to (Name of LPN (licensed practical nurse) #9. (Name of CNA #10) stated that a co-worker, CNA #2 stated that I did not do it. As per (Name of CNA #10)'s statement she assumed that (Name of CNA #11) was the person who restrained (Name of Resident #91). On July 27, 2018 on the 3-11 shift there were three CNA's (Name of CNA #10, Name of CNA #2, Name of CNA #11 and one LPN, (Name of LPN #5). (Name of CNA #10) did not recall the date of the first incident but witnessed (Name of CNA#12 (another CNA)) restraining (Name of Resident #91) with a sheet to a chair. (Name of CNA #10) reported the incident to (Name of LPN #9)... Actions taken: Virginia Beach Police Department was contacted on July 30th, 2018 and investigated the allegation of abuse and found no injuries on (Name of Resident #91)...A full body assessment was completed on (Name of Resident #91) showing no bruises or skin tears. Care Plan was updated. Social Service	F 609		

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F 609	Continued From page 60 Interviewed (Name of Resident #91) and interviewable residents on W-3. 100 % (percent) body assessments were completed on all residents in the facility. 100 % of employees were re-Education (sic) was completed on Resident Abuse. 100 % of employees were re-education (sic) on reporting abuse timely. Monitoring will be conducted by designated staff to complete walking rounds to look for signs of abuse and interview random residents concerning abuse. Delegated staff conducting the rounds will use a form and results of the rounds will be presented to the monthly QAPI. CEO (Chief executive operator) and DON will speak at the next Resident Council Meeting in August concerning resident abuse. Resident council president will invite the local ombudsman to speak at the resident council meeting in October 2018 on Resident Rights and Resident Abuse. Summary: After reviewing witness statements and interviewing employees it is my conclusion that with overwhelming evidence from the eye witness, I substantiate that (Name of Resident #91) was inappropriately restrained with no injuries. Name of (CNA#12) C.N.A will be terminated on August 2, 2018. (Name of CNA #11), C.N.A will be terminated on August 3, 2018. (Name of LPN #9), LPN will be terminated on August 2, 2018. (Name of LPN #5) will be given a written warning on August 3, 2018." Review of Resident #91's file revealed a thorough investigation was conducted on 7/29/18 by the facility. Abuse was denied by the accused staff members during interviews. A QAPI four point plan of correction was also created on August 6th and implemented. Staff, including unlicensed staff, were re-educated on the abuse policy and improper restraints on August 10th, 2018.	F 609		

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F 609	Continued From page 61 Review of a letter dated 9/11/18 from the Department of Health Professions, revealed that the two accused C.N.As were reported to the Board of Nursing. Review of the termination forms from human resources revealed that CNA #12, CNA #11 and LPN #9 were terminated on 8/2/18 and 8/3/18. Resident #91's comprehensive care plan was revised on 7/29/18 to reflect the alleged abuse. The following was documented: "(Name of Resident #91) has been allegedly physically abuse (sic) CNA reported the abused (sic)... (Name of Resident #91) will remain safe and will have no repeated incidence of alleged abuse...Abuse Coordinator immediately notified, Follow facility protocol, Notify MD (medical doctor)/RP (responsible party), Document Interventions." CNA #10, #11, #12 and LPN #9 could not be reached for an interview during the survey. On 4/3/19 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #1, the CEO and the abuse coordinator. When asked the process if a resident reported an allegation of abuse by a staff member, ASM #1 stated that he would first remove the staff member from the resident to ensure resident safety, and suspend the staff member pending further investigation. ASM #1 stated that if abuse or injury was founded, he would immediately report abuse to the appropriate state agencies within the two hour time frame. If injury was not found, he would report all allegations of abuse within 24 hours. ASM #1 stated that he would	F 609		

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F 609	Continued From page 62 interview the resident involved and other residents on the unit if the resident was not cognitively intact. ASM #1 stated that the resident involved would also be assessed for injuries. On 4/4/19 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #3, a random nurse. When asked if restraints were allowed in the facility, LPN #3 stated that restraints were not allowed in the facility. When asked of restraining a resident to a chair with bed sheets or plastic bags was abuse, LPN #2 stated, "Yes, that is considered abuse." When asked her process if it was reported to her that a resident was inappropriately restrained with a bed sheet or plastic bag, LPN #2 stated that she would remove the resident from the situation and report right away to the CEO (Chief Executive Officer). On 4/4/19 at 3:30 p.m., an interview was conducted with ASM #1. When asked if he could explain what had happened to Resident #91 on 7/27/18, ASM #1 stated that on 7/29/18 he had received a call from the DON (director of nursing) saying that a CNA (CNA #10) had witnessed (CNA #12) tie the resident to her chair with a bed sheet. ASM #1 stated that he instructed the DON to remove CNA #12 from her assignment and she was suspended pending the investigation. ASM #1 stated that they submitted a FRI within the 24 hour reporting period and also reported this allegation to APS (adult protective services) and the police. ASM #1 stated that they notified Resident #91's RP (responsible party) and the medical doctor. ASM #1 stated that a complete head to toe body assessment was conducted on Resident #91 and no injuries were found. ASM #1 stated that witness statements and skin assessments were conducted on all residents	F 609		

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F 609	Continued From page 63 residing on wing 3. ASM #1 stated that witness statements were also obtained from staff members on wing 3. ASM #1 stated that after interviewing CNA #10, it was determined that Resident #91 was restrained on two different occasions, one unknown date with a bed sheet and on 7/27/18 with plastic bags. ASM #1 stated that CNA #10 claimed that she had reported both incidents to the LPNs on the unit at the time of the incidents. ASM #1 stated that the following Monday 7/30/18, the Virginia Beach Police Department came to investigate the incident. ASM #1 stated that Resident #91 was assessed again by the police with no injuries noted. ASM #1 stated that on 8/2/18, a five day follow up to the FRI was faxed to the appropriate state agencies and he concluded with overwhelming evidence that Resident #91 was inappropriately restrained on two different occasions. ASM #1 stated that all staff were re-educated on the abuse policy including reporting abuse in a timely manner. ASM #1 stated that staff were also re-educated on restraints. ASM #1 stated that this education was part of the facility's 4 point plan of correction. ASM #1 stated that the administrative staff were also directed to monitor the units to ensure residents were free from abuse. ASM #1 stated again that he was not made aware until 7/29/18 (two days) after the last incident. On 4/3/19 at 2:35 p.m., ASM #1 was made aware of the above concern. 2. For Resident #66, facility staff failed to report an allegation of sexual abuse to the appropriate state agencies on 5/15/18. Resident #66 was admitted to the facility on 10/11/13 and readmitted on 7/24/14 with	F 609		

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F 609	Continued From page 64 diagnoses that included but were not limited to major depressive disorder, type two diabetes mellitus, and cerebrovascular disease. Resident #66's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/19/19. Resident #66 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded as requiring one person physical assist with bathing. On 3/20/19 a complaint was submitted to the OLC (Office of Licensure and Certification) regarding sexual abuse between a CNA (certified nursing assistant) and Resident #66. On 4/2/19 at 10:16 a.m., an interview was conducted with Resident #66. Resident #66 denied any abuse from staff members. Resident #66 declined further interview and asked this writer to leave her room. Review of Resident #66's clinical record revealed that she had filed a grievance with the social worker on 5/15/18. The following was documented by the social worker: "Describe concern in detail: CNA(certified nursing assistant) (Name of CNA #16) made her uncomfortable during shower. said (sic) "I'll wash your back if you wash my back." Was not using washcloth to wash her back-did not want him to use bare hands. Staff member assigned responsibility for the investigation: (Name of CEO (Chief Executive Officer)), Assigned by SS (Social Services). Date assigned: 5/15/18. Findings of investigation: Spoke to (Name of CNA #16) at 3:00 PM on 5-16-18 concerning the care given during a	F 609		

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 609	Continued From page 65	F 609		

shower to resident. He stated that he did shower resident and was using gloves. He denied saying "I'll wash your back if you wash my back."' Plan to resolve complaint/grievance: (Name of CNA #16) will use a washcloth and gloves during care. 2 Warned that comments as described would not be tolerated." Results of actions taken: Spoke with (Name of Resident #66) and told her that (Name of CNA #16) will use gloves and washcloth during care."

There was no evidence in the clinical record that all residents on the unit were interviewed regarding CNA #16. There was no evidence that the CNA #16 was suspended pending investigation.

Review of the staff sheets dated 5/2018 through 6/2018 revealed that CNA #16 was reassigned after this incident to a different unit.

Review of the staff sheets from the last three months revealed that CNA #16 identified had not been working with Resident #66.

Review of the CNA #16's employee file revealed that the employee had no previous history of any barrier crimes.

Review of Resident #66's comprehensive care plan dated 2/21/19 failed to evidence this allegation of sexual abuse.

On 4/3/19 at 1:26 p.m., an interview was conducted with OSM (other staff member) #1, the social worker. When asked how she would take the above statement made by the CNA, OSM #1 stated, "It made my skin crawl." When asked if she would consider that statement abuse, OSM

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F 609	Continued From page 66 #1 stated, "Yes, I would consider that sexual abuse." OSM #1 stated that she reported this allegation to the administrator. On 4/3/19 at 2:25 p.m., an interview was conducted with CNA (certified nursing assistant) #16, the CNA identified in the grievance. When asked what he could recall about the incident with Resident #66, CNA #16 stated that he was helping her with her shower and that the resident claimed he was not wearing any gloves while he was assisting. CNA #16 stated that he was wearing gloves but apologized to the resident anyway. CNA #16 stated that Resident #66 accepted his apology and assured her that it wouldn't happen again. CNA #16 stated that he is not allowed to be assigned to her and that he was moved from her care. CNA #16 stated that he did not recall making the above statement. CNA #16 stated that he was not suspended. CNA #16 stated that ASM #1 had talked to him and he had apologized to the resident the same day. On 4/3/19 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #1, the CEO and the abuse coordinator. When asked the process if a resident reported an allegation of abuse by a staff member, ASM #1 stated that he would first remove the staff member from the resident to ensure resident safety, and suspend the staff member pending further investigation. ASM #1 stated that if abuse or injury was founded, he would immediately report abuse to the appropriate state agencies within the two hour time frame. If injury was not found, he would report all allegations of abuse within 24 hours. ASM #1 stated that he would interview the resident involved and other residents on the unit if the resident was not	F 609		

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F 609	Continued From page 67 cognitively intact. ASM #1 stated that the resident involved would also be assessed for injuries. When asked what he could remember about Resident #66 and the male CNA, ASM #1 stated that he thought the CNA grabbed her. ASM #1 could not recall the CNA making an inappropriate statement. This writer let ASM #1 read the grievance report. ASM #1 then stated, "He denied saying that." ASM #1 stated that he did not report this allegation to the appropriate state agencies. ASM #1 stated that he moved the CNA to another unit. When asked if the statement made by the CNA was inappropriate, ASM #1 stated that it was. When asked if the above comment was abuse, ASM #1 stated that it was verbal abuse and that it should have been reported. ASM #1 stated that he did not conduct an investigation ASM #1 stated that the CNA continued to work with residents after the reported allegation made by Resident #66. On 4/3/19 at 2:35 p.m., ASM #1 was made aware of the above concerns. 3. The facility staff failed to report an injury of unknown origin that resulted in serious bodily injury within 2 hours to the appropriate State Survey Agencies on 1/20/19 for Resident #103. Resident #103 was a 94 year old admitted to the facility on 3/19/18 with diagnoses to include but not limited to Alzheimer's Disease, Major Depressive Disorder and Falls. Resident #103's most recent Minimum Data Set (MDS) assessment was an Annual assessment with an Assessment Reference Date (ARD) of 3/19/19. Resident #103's Brief Interview for Mental Status (BIMS) indicated that the resident was rarely or never understood, had short and	F 609		

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F 609	Continued From page 68 long term memory recall issues and was severely cognitively impaired for daily decision making. Resident #103's Nurse's Notes were reviewed and are documented in part, as follows: 1/20/19 8 AM: Notified by CNA (Certified Nursing Assistant) resident have bruising to R (right) shoulder when she touched her arm. Pt. (patient) express pain. Pt. assess right shoulder bruising , red in color, swelling and warm to touch. Pt. express pain with touch stimuli. MD (medical doctor) notified new order X-ray right shoulder. RP (responsible party) made aware. Tylenol 2 tabs 650 mg(milligrams) given for pain. Mobilex notified, awaiting x-ray tech. 1/20/19 12 PM X-ray tech rendered care. Awaiting x-ray results. 1/20/19 3:30 PM: MD made aware of x-ray results. N.O. (new order) send to ER (emergency room) for evaluation and treatment. RP made aware. Resident #103's physician orders were reviewed and are documented in part, as follows: 1/20/19: Medication Order-Right shoulder X-ray two views. Indication/Diagnosis- Right shoulder bruise, swelling, pain. 1/20/19: Medication Order-Send to ER for evaluation and treatment. Indication/Diagnosis- Distal right clavicle fracture. Resident #103's Radiology Report dated 1/20/19	F 609		

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F 609	Continued From page 69 at 12:52 PM was reviewed and is documented in part, as follows: Results: There is a displaced fracture of the distal right clavicle. No significant callus formation noted and the fracture appears recent. Conclusion: Displaced distal right clavicle fracture. Fax time stamp at top of the radiology report to the facility was 1/20/19 at 12:55 PM. Resident #103's Emergency Room documentation dated 1/20/19 was reviewed and is documented in part, as follows: Diagnosis: Closed displaced fracture of acromial end of right clavicle. ED (Emergency Department) Notes/Significant Events Notes: Pt. (patient) arrived by rescue from Name (facility) for a broken RIGHT clavicle per x-rays; staff was unable to tell rescue what caused fracture. ED Attending Supervision Note: 93 year old female sent from nursing home for broken clavicle. Altered at baseline per family. Trauma unwitnessed, unknown if fell. Resident#103's Facility Reported Incident (FRI) dated 1/21/19 was reviewed and is documented in part, as follows: Report date: 1/21/2019 Incident date: 1/20/2019 Injuries: Yes, Fracture to right clavicle. Incident Type: Injury of unknown origin.	F 609		

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F 609	Continued From page 70 Describe incident, including location,and action taken: Right shoulder noted with bruising, swelling and painful to touch by CNA who reported her observation to LPN (Licensed Practical Nurse). Physician was notified and ordered an x-ray. results of x-ray obtained showing a right clavicle fracture. Orders to send resident to ER and returned to facility at 11:45 PM. If applicable, date notification provided to: Responsible Party: 1/20/19 Physician: 1/20/19 APS(Adult Protective Services): 1/21/19 Fax time stamp at top of the FRI report to the Office of Licensure and Certification was 1/21/19 at 16:25(4:25) PM. The facility policy titled "Abuse Investigation and Reporting" last revised 7/2017 was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency	F 609		

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F 609	Continued From page 71 responsible for surveying/licensing the facility. b. The local/State Ombudsman. d. Adult Protective Services (where state law provides jurisdiction in long-term care). 2. An alleged violation of abuse, neglect, exploitation, or mistreatment, (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. The facility policy titled "Abuse Prevention/Reporting Policy and Procedure" updated 5/8/18 was reviewed and is documented in part, as follows: Investigation: 7. If the crime/abuse involves serious bodily injury including criminal sexual abuse to the resident it will be reported immediately but no later than 2 hours after forming the suspicion to the local authorities and the State Department of Health. On 4/2/19 at approximately 4:15 PM an interview was conducted with the Administrator regarding Resident #103's serious bodily injury of unknown origin that occurred on 1/20/19 but not reported until 1/21/19. The Administrator stated, "The injury should have been reported within 2 hours of the facility being made aware that the resident had a fracture." On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared.	F 609		

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F 609	Continued From page 72 Prior to exit no further information was shared. This is a Complaint Deficiency.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to thoroughly investigate an allegation of abuse for two of 51 residents in the survey sample, Resident #66 and #103. 1. For Resident #66, facility staff failed to complete a thorough investigation of an allegation of sexual abuse on 5/15/18.	F 610	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Failed to complete a thorough investigation for Resident's #66 and #103. b. No further allegations of abuse for residents #66 and #103 **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected. b. No other residents have alleged any allegations of abuse. **(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. The abuse coordinator (CEO) was re-in-serviced on the Abuse Prevention/ Reporting Policy and procedure and use of restraints on 4/5/19 by Regional Quality Specialist. b. Tracking tool was created to track abuse allegations. c. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed.	

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F 610	Continued From page 73 2. For Resident #103, the facility staff failed to thoroughly investigate a serious bodily injury of unknown origin which included maintaining staff statements from the shifts prior to the injury being observed. The findings include: 1. Resident #66 was admitted to the facility on 10/11/13 and readmitted on 7/24/14 with diagnoses that included but were not limited to major depressive disorder, type two diabetes mellitus, and cerebrovascular disease. Resident #66's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/19/19. Resident #66 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded as requiring one person physical assist with bathing. On 3/20/19 a complaint was submitted to the OLC (Office of Licensure and Certification) regarding sexual abuse between a CNA (certified nursing assistant) and Resident #66. On 4/2/19 at 10:16 a.m., an interview was conducted with Resident #66. Resident #66 denied any abuse from staff members. Resident #66 declined further interview and asked this writer to leave her room. Review of Resident #66's clinical record revealed that she had filed a grievance with the social worker on 5/15/18. The following was documented by the social worker: "Describe concern in detail: CNA(certified nursing assistant)	F 610	d. All staff will be in-services on Abuse prevention/Reporting Policy and procedure by 5/3/19. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The CEO will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 610	Continued From page 74 (Name of CNA #16) made her uncomfortable during shower. said (sic) "I'll wash your back if you wash my back." Was not using washcloth to wash her back-did not want him to use bare hands. Staff member assigned responsibility for the investigation: (Name of CEO (Chief Executive Officer)), Assigned by SS (Social Services). Date assigned: 5/15/18. Findings of investigation: Spoke to (Name of CNA #16) at 3:00 PM on 5-16-18 concerning the care given during a shower to resident. He stated that he did shower resident and was using gloves. He denied saying "I'll wash your back if you wash my back."' Plan to resolve complaint/grievance: (Name of CNA #16) will use a washcloth and gloves during care. 2 Warned that comments as described would not be tolerated." Results of actions taken: Spoke with (Name of Resident #66) and told her that (Name of CNA #16) will use gloves and washcloth during care." There was no evidence in the clinical record that residents on the unit were interviewed regarding CNA #16. There was no evidence that the CNA #16 was suspended pending investigation. Review of the staff sheets dated 5/2018 through 6/2018 revealed that CNA #16 was reassigned after this incident to a different unit. Review of the staff sheets from the last three months revealed that CNA #16 identified had not been working with Resident #66. Review of the CNA #16's employee file revealed that the employee had no previous history of any barrier crimes. Review of Resident #66's comprehensive care	F 610		

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F 610	Continued From page 75 plan dated 2/21/19 failed to evidence this allegation of sexual abuse. On 4/3/19 at 1:26 p.m., an interview was conducted with OSM (other staff member) #1, the social worker. When asked how she would take the above statement made by CNA #16, OSM #1 stated, "It made my skin crawl." When asked if she would consider that statement abuse, OSM #1 stated, "Yes, I would consider that sexual abuse." OSM #1 stated that she reported this allegation to the administrator. On 4/3/19 at 2:25 p.m., an interview was conducted with CNA (certified nursing assistant) #16, the CNA identified in the grievance. When asked what he could recall about the incident with Resident #66, CNA #16 stated that he was helping her with her shower and that the resident claimed he was not wearing any gloves while he was assisting. CNA #16 stated that he was wearing gloves but apologized to the resident anyway. CNA #16 stated that Resident #66 accepted his apology and assured her that it wouldn't happen again. CNA #16 stated that he is not allowed to be assigned to her and that he was moved from her care. CNA #16 stated that he did not recall making the above statement. CNA #16 stated that he was not suspended. CNA #16 stated that ASM #1 had talked to him and he had apologized to the resident the same day. On 4/3/19 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #1, the CEO and the abuse coordinator. When asked the process if a resident reported an allegation of abuse by a staff member, ASM #1 stated that he would first remove the staff member from the resident to ensure resident	F 610		

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F 610	Continued From page 76 safety, and suspend the staff member pending further investigation. ASM #1 stated that if abuse or injury was founded, he would immediately report abuse to the appropriate state agencies within the two hour time frame. If injury was not found, he would report all allegations of abuse within 24 hours. ASM #1 stated that he would interview the resident involved and other residents on the unit if the resident was not cognitively intact. ASM #1 stated that the resident involved would also be assessed for injuries. When asked what he could remember about Resident #66 and the male CNA, ASM #1 stated that he thought the CNA grabbed her. ASM #1 could not recall the CNA making an inappropriate statement. This writer let ASM #1 read the grievance report. ASM #1 then stated, "He denied saying that." ASM #1 stated that he did not report this allegation to the appropriate state agencies. ASM #1 stated that he moved the CNA to another unit. When asked if the statement made by the CNA was inappropriate, ASM #1 stated that it was. When asked if the above comment was abuse, ASM #1 stated that it was verbal abuse and that it should have been reported. ASM #1 stated that he did not conduct an investigation ASM #1 stated that the CNA continued to work with residents after the reported allegation made by Resident #66. On 4/3/19 at 2:35 p.m., ASM #1 was made aware of the above concern. 2. For Resident #103, the facility staff failed to thoroughly investigate a serious bodily injury of unknown origin which included maintaining staff statements from the shifts prior to the injury being observed. Resident #103 is a 94 year old admitted to the	F 610		

Survey Response Form

The LTC Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at:
"http://www.vdh.virginia.gov/content/uploads/sites/96/2019/02/LTC-facility-survey-response-form.pdf"
We will appreciate your participation.

If you have any questions concerning this letter, please contact me at 804/367-2100.

Sincerely,

Laura Syracuse Veuhoff

Laura S. Veuhoff, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman (Sent Electronically)
Bertha Ventura, Dmas (Sent Electronically)

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F 610	Continued From page 77 facility on 3/19/18 with diagnoses to include but not limited to Alzheimer's Disease, Major Depressive Disorder and Falls. Resident #103's most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 3/19/19. Resident #103's Brief Interview for Mental Status (BIMS) indicated that the resident was rarely or never understood, had short and long term memory recall issues and was severely cognitively impaired for daily decision making. Resident #103's Nurse's Notes were reviewed and are documented in part, as follows: 1/20/19 8 AM: Notified by CNA (Certified Nursing Assistant) resident have bruising to R(right) shoulder when she touched her arm. Pt.(patient) express pain. Pt. assess right shoulder bruising , red in color, swelling and warm to touch. Pt. express pain with touch stimuli. MD (medical doctor) notified new order X-ray right shoulder. RP (responsible party) made aware. Tylenol 2 tabs 650 mg(milligrams) given for pain. Mobilex notified, awaiting x-ray tech. 1/20/19 12 PM X-ray tech rendered care. Awaiting x-ray results. 1/20/19 3:30 PM: MD made aware of x-ray results. N.O. (new order) send to ER (emergency room) for evaluation and treatment. RP made aware. Resident #103's physician orders were reviewed and are documented in part, as follows: 1/20/19: Medication Order-Right shoulder X-ray	F 610		

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F 610	Continued From page 78 two views. Indication/Diagnosis- Right shoulder bruise, swelling, pain. 1/20/19: Medication Order-Send to ER for evaluation and treatment. Indication/Diagnosis- Distal right clavicle fracture. Resident #103's Radiology Report dated 1/20/19 at 12:52 PM was reviewed and is documented in part, as follows: Results: There is a displaced fracture of the distal right clavicle. No significant callus formation noted and the fracture appears recent. Conclusion: Displaced distal right clavicle fracture. Fax time stamp at top of the radiology report to the facility was 1/20/19 at 12:55 PM. Resident #103's Emergency Room documentation dated 1/20/19 was reviewed and is documented in part, as follows: Diagnosis: Closed displaced fracture of acromial end of right clavicle. ED (Emergency Department) Notes/Significant Events Notes: Pt. (patient) arrived by rescue from Name (facility) for a broken RIGHT clavicle per x-rays; staff was unable to tell rescue what caused fracture. ED Attending Supervision Note: 93 year old female sent from nursing home for broken clavicle. Altered at baseline per family. Trauma	F 610		

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F 610	Continued From page 79 unwitnessed, unknown if fell. Resident#103's Facility Reported Incident (FRI) dated 1/21/19 was reviewed and is documented in part, as follows: Report date: 1/21/2019 Incident date: 1/20/2019 Injuries: Yes, Fracture to right clavicle. Incident Type: Injury of unknown origin. Describe incident, including location,and action taken: Right shoulder noted with bruising, swelling and painful to touch by CNA who reported her observation to LPN (Licensed Practical Nurse). Physician was notified and ordered an x-ray. results of x-ray obtained showing a right clavicle fracture. Orders to send resident to ER and returned to facility at 11:45 PM. If applicable, date notification provided to: Responsible Party: 1/20/19 Physician: 1/20/19 APS(Adult Protective Services): 1/21/19 Fax time stamp at top of the FRI report to the Office of Licensure and Certification was 1/21/19 at 16:25(4:25) PM. The facility's 5 Day Investigation for Resident #103's serious bodily injury of unknown origin dated 1/23/19 was reviewed and is documented in part, as follows: Investigation: On 1/20/19 all unit employees on the 7-3, 3-11, and 11-7 shift were interviewed and completed written statements.	F 610		

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F 610	Continued From page 80 Summary: After reviewing all witness statements and receiving the resident interview by Social Services I conclude that the injury of unknown injury was as a result of Name (Resident #103) falling between the hours of 11:00 PM to 7:00 AM. On 04/03/19 04:26 PM the Director of Nursing was asked for the staff statements that were obtained during the investigation of Resident #103's right clavicle fracture of unknown origin on 1/20/19. On 04/03/19 02:31 PM the Director of Nursing was asked if she was able to obtain the staff statements. The Director of Nursing stated, "No we don't have them, the Administrator said they were done but we can't find them." On 04/03/19 05:00 PM an interview was conducted with the Administrator regarding his investigation of Resident #103's fractured clavicle to include the staff statements and who was instructed to update the resident's plan of care to include non-skid socks. The Administrator stated, "I can't find the staff statements that were done with the initial investigation, they (the staff members) are all still here I can have them rewrite them. I told Name (MDS Coordinator) to update the care plan regarding the non skid socks." The facility policy titled "Abuse Investigation and Reporting" last revised 7/2017 was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to	F 610		

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F 610	Continued From page 81 local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. 2. The following guidelines will be used when conducting interviews: d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. The facility policy titled "Abuse Prevention/Reporting Policy and Procedure" updated 5/8/18 was reviewed and is documented in part, as follows: Investigation: 9. The Administrator and the D.O.N. (Director of Nursing) will conduct a comprehensive investigation of any and ALL allegations of abuse/neglect or misappropriation of resident property in accordance with state law, federal regulation and The Patient Protection and Affordable Care Act (Elder Justice Act). 10. The investigating team will interview all parties concerned: witnesses, staff, the accused and the alleged victim as appropriate and obtain signed statements as possible. On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality	F 610		

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F 610	Continued From page 82 Specialist where the above information was shared. Prior to exit no further information was shared. This is a Complaint Deficiency.	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate.	F 622	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #24, #59, #368, #76, #119 were discharged to the hospital and had returned making it unable to send care plan goals. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who are discharged/ transferred to a higher level of care have the potential to be affected by the deficient practice.	

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F 622	Continued From page 83 (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider	F 622	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. The Director of Nursing was in-serviced by the Regional Quality Specialist on 4/5/19 over the Transfer/Discharge Policy and Procedure emphasizing that care plan goals are to be sent with the resident. b. All licensed nurses were in-serviced over the Transfer/Discharge Policy and Procedure by the Director of Nursing or Assistant Director of Nursing instructing nurses to ensure care plan goals were sent with the resident on discharge. This education was completed on May 3, 2019 c. A monitoring tool was developed to audit residents who are discharged/ transferred auditing that the care plan goals were sent with the resident. d. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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F 622	Continued From page 84 must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan for five of 51 residents (Resident #24, #59, #368, #76 and #119) after being transferred to the hospital. 1. The facility staff failed to send Resident #24's Care Plan Summary to include their goals when discharged to the hospital on 01/08/19. 2. The facility staff failed to convey Resident #59's Individual Plan of Care summary upon discharge to the psychiatric hospital on 1/7/19. 3. The facility staff failed to send Resident #368's Comprehensive Resident-Centered Plan of Care upon transfer to the local hospital on 09/10/18. 4. The facility staff failed to send Resident #76's care plan summary when discharged to the hospital on 02/08/19.	F 622	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 622	Continued From page 85 5. The facility staff failed to ensure that Resident #119's Plan of Care Summary to include care plan goals was sent upon transfer to the hospital on 2/25/19. The findings included: 1. Resident #24 was originally admitted to the facility on 10/13/18. The resident was readmitted on 01/11/19. Diagnosis for Resident #24 included but not limited to *End Stage Renal Failure (ESRD). *ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure). The current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 01/22/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments dated 01/08/19-discharge return anticipated, resident readmitted on 01/11/19. According to facility documentation, on 01/08/19 at approximately 5:00 p.m., Resident #24 was administered Zofran for nausea. On the same day at 9:30 p.m., the resident was throwing up blood (moderate) amount and still complaining of nausea. Resident #24 was transported to the local ER via Emergency Medical Services (EMS).	F 622		

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F 622	Continued From page 86 An interview was conducted with License Practical Nurse (LPN) #3 on 04/03/19 at approximately 10:40 a.m. The surveyor asked, "What paperwork is sent with the resident when they are being sent out to the hospital." The nurse replied, "I will send the resident's face sheet, recent labs, progress note, their Physician Order Sheet (POS), the order to send them out and their Do Not Resuscitate (DNR) Form." The surveyor asked, "Do you send the resident's personalized care plan which includes their goals that has been set by the facility." The LPN stated, "I do not send the resident's care plan; I did not know I was suppose too." On 04/03/19 at approximately 10:43 a.m., an interview was conducted with LPN #4. The surveyor asked, "When you send a resident out to the hospital for evaluation, do you send their care plan summary which includes their goals?" The LPN replied, "No, I was not aware that we needed to be send their care plan." An interview was conducted with the facilities Regional Quality Specialist (RQS) on 04/04/19 at 10:28 a.m.. The surveyor asked, "When a resident is being sent out the hospital, should the resident's personalized care plan summary be sent with them" she replied "Yes." The surveyor asked, "What is the purpose for sending the residents care plan" she replied, "To let the receiving provider know where the resident goals are that we have set for them and their family." She said there was a conference call with Administration in November 2017, when the new regulation went into effect. She said the facility never implemented the new process. The facility administration was informed of the	F 622		

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F 622	Continued From page 87 finding during a briefing on 04/04/19 at approximately 6:05 p.m. The facility did not present any further information about the findings. 2. The facility staff failed to convey Resident #59's Individual Plan of Care summary upon discharge to the psychiatric hospital on 1/7/19. Resident #59 was originally admitted to the facility 6/14/18, and was readmitted to the facility 1/31/19, after a psychiatric hospital stay. The current diagnoses included; schizophrenia, hepatitis and renal insufficiency. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/12/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of 15. This indicated Resident #59's daily decision making abilities were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with eating and locomotion, limited assistance of one with bed mobility and transfers, extensive assistance of one person with toileting, and total care of one with dressing, personal hygiene and bathing. Review of the discharge MDS assessment dated 1/7/19, revealed Resident #59 was discharged-return not anticipated. Review of the clinical record revealed a nurse's note dated 1/7/19, at 5:00 p.m., which included Resident #59 was admitted to a local psychiatric hospital for altered mental status. No documentation was included which stated the	F 622		

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F 622	Continued From page 88 facility staff conveyed to the receiving providers, the resident's summary of the comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer. On 4/2/19 at approximately 2:30 p.m., the Unit Manager stated at the time of Resident 59's hospital transfer the facility staff was not aware of the requirement to provide a copy of the resident's care plan summary to the receiving provider, therefore; notification was not provided. 3. The facility staff failed to send Resident #368's Comprehensive Resident-Centered Plan of Care upon transfer to the hospital. Resident #368 was admitted to the facility on 01/20/17, readmitted to the facility on 09/25/18, and discharged on 10/02/18. Diagnoses for Resident #368 included but not limited to Dementia and Anxiety Disorder. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 09/10/18 coded the resident as having short term memory problems. And discharge return anticipated; re-admitted to the facility on 10/01/18. According to the facility's documentation on 09/10/18, Resident #368 was transferred to the local hospital ER (emergency room) via 911 with diagnosis of hypernatremia (high sodium level). Two attempts were made to contact Responsible Party (RP). On 09/12/18 a progress note read "This resident is at local hospital. Spoke to JFS (Jewish Family Services) case manager. A communication sheet dated 09/11/8 stated that Resident #368 was transferred to the Emergency Room on 09/10/18.	F 622		

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 622	Continued From page 89 A brief interview was conducted with the MDS Coordinator (Registered Nurse #1) on 04/03/19 at approximately 2:40 PM. She stated that she didn't send a care plan to the hospital with the resident because he was transported to the Emergency Room. On 04/04/19 at approximately 5:30 PM the Administrator and Director of Nursing were informed of the above findings. No comments were made. 4. The facility staff failed to send Resident #76's care plan summary when discharged to the hospital on 02/08/2019. Resident #76 was discharged to the hospital on 02/08/2019 and readmitted to the facility on 02/20/2019. Diagnoses included but were not limited to, Diabetes Mellitus and Quadriplegia. Resident #76's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/27/2019 coded Resident #76 with short-term memory problems and long-term memory problems. In addition, the Minimum Data Set coded Resident #76 as requiring extensive assistance of 2 with bed mobility and toilet use, extensive assistance of 1 with dressing, eating and personal hygiene and total dependence of 1 with bathing. On 04/04/2019 at 4:50 p.m., an interview was conducted with Licensed Practical Nurse (LPN # 3) and she was asked, "What documents do you send out with a resident when they are discharged to the hospital?" LPN #3 stated, "DNR (Do Not Resuscitate) sheet if applicable, Physician Order Sheet, History and Physical,	F 622		

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F 622	Continued From page 90 recent labs, face sheet and progress notes." Surveyor asked LPN #3, "Were you aware that you should send the resident's care plan summary when transferring the resident to the hospital?" LPN #3 stated, "No I was not aware until this week when I was told that I should." On 04/04/2019 at approximately 4:50 p.m., an interview was conducted with LPN #1 and she was asked, "What documents do you send out with a resident when they are discharged to the hospital?" LPN #1 stated, "DNR Sheet if applicable, Physician Order Sheet, History and Physical, recent labs, face sheet and progress notes." Surveyor asked LPN #1, "Were you aware that you should send the resident's care plan summary when transferring the resident to the hospital?" LPN #1 Stated, "No I was not aware." The administrative team was informed of the finding on 04/04/2019 at approximately 6:00 p.m. No further information was provided about the finding. 5. The facility staff failed to ensure that Resident #119's Plan of Care Summary to include care plan goals was sent upon transfer to the hospital on 2/25/19. Resident #119 was a 77 year old admitted to the facility on 2/19/19 and was discharged on 2/25/19. Resident #119's diagnoses included but were not limited to Type 2 Diabetes Mellitus, Anxiety Disorder, and Stage 3 Chronic Kidney Disease. The most recent Minimum Data Set (MDS) Assessment was a 5 day Discharge-return not anticipated with an Assessment Reference Date	F 622		

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F 622	Continued From page 91 (ARD) of 2/25/19. Resident #119's Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #119's Nurse's Notes were reviewed and are documented in part, as follows: 2/25/19 1PM: Upon further assessment it appears that resident is presenting with JVD (jugular vein distention), present on both sides of resident's neck. He continues to cough up sputum that is blood tinged. Unable to fully assess lung fields related to shallow breathing. MD (Medical doctor) notified. New order send resident to ED (emergency department) for further evaluation. Resident is self RP (responsible party) and aware. EMT's (emergency medical technicians) present for transfer to Name (hospital). Report given to ED. Resident currently enroute to ED. 2/25/19 8PM: Called placed to Name (hospital) stated patient will be admitted). Resident #119's Physician Orders were reviewed and are documented in part, as follows: 2/25/19 Patient may be sent out by 911. Resident #119's Care Plan dated 2/20/19 was reviewed and indicated the following problem onsets with goals for the resident which are documented in part, as follows: 1. Needs reminders and encouragement to participate in activities of choice. 2. Has potential for falls. 3. Has potential for dehydration.	F 622		

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F 622	Continued From page 92 4. Is at risk for impaired skin integrity. 5. Continues to need assistance with completion of activities of daily living related to diagnosis. 6. Has the potential for weight variances. 7. Has the potential for pain related to diagnosis. 8. Is at risk for constipation related to limited mobility and diagnosis. On 04/03/19 04:51 PM an interview was conducted with the Director of Nursing regarding what documentation is sent with a resident upon discharge to the hospital. The Director of Nursing stated, "I already told someone else I don't have knowledge about a bed hold or a care plan needing to be sent out with discharges. As far as I know the business office deals with the bed holds the next day after our daily standup meeting." On 04/03/19 05:59 PM an interview was conducted with the Corporate Quality Specialist Nurse regarding care plans and bed holds being sent upon discharges. The Corporate Quality Assurance Nurse stated, "We were aware of the new regulations and we had a conference call with the CEO's and the DON's about 8 months ago to inform them of the changes." The facility policy titled "Transfer Discharges, Emergency" revised 2016 was reviewed and is documented in part, as follows: Policy Interpretation and Implementation: 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: e. Prepare and send the resident's care plan goals.	F 622		

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F 622	Continued From page 93 On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared. Prior to exit no further information was shared.	F 622		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be 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;	F 623	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Notification was not sent to the Office of the State Long-Term care Ombudsman for resident's #24, #76, #368, #59 and #105. b. On April 4, 2019 the Social Worker revised the discharged listing that included residents #24, #76, #368, #59, and #105 and sent it to the Office of the State Long-Term care Ombudsman. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected.	

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F 623	Continued From page 94 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related 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	F 623	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. Social Worker was re-educated on the policy and procedure for notifying the Office of the State Long-Term care Ombudsman on 4/5/2019. b. Social Worker re-sent the revised discharge listing which included residents #76, #368, #59 and #105 to the Office of the State Long-Term care Ombudsman on April 4, 2019. c. Social Worker is using a tracking form to ensure compliance prior to sending the monthly discharge listing. d. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Social Services will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 623	Continued From page 95 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for five of 51 residents (Resident #24, #76, #368, #59, #105) in the survey sample. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #24's transfer and admission to the local hospital on 02/09/19.	F 623		

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F 623	Continued From page 96 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #76's discharge to the hospital on 02/08/2019. 3. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #368's transfer to the local hospital on 09/10/18. 4. The facility staff failed to notify the Long-Term Care Ombudsman of Resident #59's discharge and admission to a psychiatric hospital on 1/7/19. 5. The facility staff failed to provide Resident #105 with a notice of discharge and send a copy to the Office of the State Long-Term Care Ombudsman. The finding included: 1. Resident #24 was originally admitted to the facility on 10/13/18. The resident was readmitted on 01/11/19 and 02/14/19. Diagnosis for Resident #24 included but not limited to End Stage Renal Failure (ESRD). The current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 01/22/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments dated 02/09/19-discharge return anticipated. According to the facility's documentation on 02/09/19 at 6:30 a.m., Resident #24 was taken to	F 623		

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F 623	Continued From page 97 dialysis via stretcher. An interview was conducted with License Practical Nurse (LPN) #3 on 04/03/19 at approximately 10:40 a.m. She said Resident #24 was transferred to the hospital from dialysis and admitted on 02/09/19. On 04/03/19 at approximately at 1:00 p.m., an interview was conducted with the Social Worker (SW) who stated, "I did not notify the Ombudsman of Resident #24's transfer and admission to the hospital on 02/09/19." The SW stated, "When the discharge list was ran at the end of the month; his name did not roll over onto the list." She said the Ombudsman was never notified of Resident #24's discharge on 02/09/19. The facility administration was informed of the finding during a briefing on 04/04/19 at approximately 6:05 p.m. The facility did not present any further information about the findings. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #76's discharge to the hospital on 02/08/2019. Resident # 76 was discharged to the hospital on 02/08/2019 and readmitted to the facility on 02/20/2019. Diagnosis included but were not limited to, Diabetes Mellitus and Quadriplegia. Resident #76's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/27/2019 coded Resident #76 with short-term memory problems and long-term memory problems. In addition, the Minimum Data Set coded Resident #76 as requiring extensive assistance of 2 with bed mobility and toilet use, extensive assistance of 1 with dressing, eating and personal hygiene and	F 623		

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F 623	Continued From page 98 total dependence of 1 with bathing. On 04/03/2019 at 1:00 p.m., an interview was conducted with the Social Worker. The Surveyor asked the Social Worker, "Was the Ombudsman notified of Resident #76's discharge to the hospital on 02/08/2019?" The Social Worker stated, "No the Ombudsman was not notified in February. I ran the end of the month report for the residents discharged but I did not remember to send the notice to the local Ombudsman because his name was not in my report. If the resident is on a bed hold-the report does not always pull off that resident's name." The administrative team was informed of the finding on 04/04/2019 at approximately 6:00 p.m. No further information was provided about the finding. 3. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #368's transfer to the local hospital on 09/10/18. Resident #368 was admitted to the facility on 01/20/17, readmitted to the facility on 09/25/18 then discharged on 10/02/18. Diagnosis for Resident #368 included but not limited to Dementia and Anxiety Disorder. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 09/10/18. Staff assessment of mental status coded the resident as having short term memory problems. Discharge return anticipated; re-admitted to the facility on 10/01/18. On 09/10/18, according to the facility's	F 623		

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F 623	Continued From page 99 documentation, Resident #368 was transferred to the local hospital ER via 911 with diagnosis of hypernatremia. A brief interview was conducted with The MDS Coordinator (Registered Nurse #1) on 04/03/19 at approximately 6:38 PM. She stated that she printed the discharged residents report for the month of September 2018 but the above resident's name did not appear on the report. On 04/04/19 at approximately 5:30 PM the Administrator and Director of Nursing they were informed of the above findings. No comments were made. 4. The facility staff failed to notify the Long-Term Care Ombudsman of Resident #59's discharge and admission to a psychiatric hospital, 1/7/19. Resident #59 was originally admitted to the facility 6/14/18, and was readmitted to the facility 1/31/19, after a psychiatric hospital stay. The current diagnoses included; schizophrenia, hepatitis and renal insufficiency. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/12/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of 15. This indicated Resident #59's daily decision making abilities were moderately impaired. Review of the discharge MDS assessment dated 1/7/19, revealed Resident #59 was discharged-return not anticipated. Review of the clinical record revealed a nurse's note dated 1/7/19, at 5:00 p.m., which stated	F 623		

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F 623	Continued From page 100 Resident #59 was admitted to a local psychiatric hospital for altered mental status. On 4/2/19 at approximately 1:30 p.m., an interview was conducted with the Social Worker. The Social Worker stated review of the list of discharges sent to the Long-Term Care Ombudsman for January 2019, didn't include Resident #59's name therefore; notification was not provided. 5. The facility staff failed to provide Resident #105 with a notice of discharge and send a copy to the office of the Ombudsman. Resident #105 was admitted to the facility 05/02/18 with diagnoses which included heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, end stage renal disease, and left below knee amputee. Resident #105 was sent out to the hospital on 2/12/19. A review of the clinical records did not include a discharge notice or that a copy of her discharge notice sent to the Ombudsman office. A Minimum Data Set dated 3/16/19 assessed this resident has having a BIMS score of 11. This resident was assessed as having no hearing, speech or vision difficulty. A review of the clinical records indicated that on February 12, 2019, Resident #105 was admitted to the hospital for pneumonia. A review of the clinical records did not indicate that Resident #105 was provided with a discharge notice nor was a copy of her discharge notice sent to the Ombudsman office. During an interview on 4/3/19 at 2:30 P.M. with the facility Social Worker, she stated, Resident	F 623		

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BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 623	Continued From page 101 #105 was not provided with a discharge notice nor was a notice sent to the Ombudsman office. The facility staff failed to provide Resident #105 with a discharge notice and send a notice of discharge to the Ombudsman office.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #24, #76, #368, #59, #105 were discharged to the hospital and had returned making it unable to send the bed hold policy. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who are discharged/ transferred to a higher level of care have the potential to be affected by the deficient practice.	

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F 625	Continued From page 102 by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed send a copy of the Bed-Hold Policy for six of 51 residents (Resident #24, #59, #76, #368,#119, and #105) after being transferred to and admitted to the hospital. 1. The facility staff failed to ensure that Resident #24 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 01/08/19. 2. The facility's staff failed to provide written information to the resident or resident representative which specifies the duration of the bed-hold policy upon transfer to the local psychiatric hospital on 1/7/19 for Resident #59. 3. Resident #76 was discharged to the hospital on 02/08/2019 and the facility staff failed to provide the Resident and/or Resident Representative a written Bed Hold Notice. 4. The facility staff failed to ensure that Resident #368 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 09/10/18. 5. The facility staff failed to provide Resident #119 with a written copy of the bed hold policy upon transfer to the hospital on 2/25/19. 6. The facility staff failed to provide Resident #105 with written information of the facility's bed hold policy. The findings included:	F 625	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. The Director of Nursing and Social Service Director were in-serviced by the Regional Quality Specialist on 4/5/19 over the Transfer/Discharge Policy and Procedure emphasizing that the bed hold policy is to be sent with the resident on discharge to a higher level of care. b. All licensed nurses were in-serviced over the Transfer/Discharge Policy and Procedure by the Director of Nursing or Assistant Director of Nursing instructing nurses to ensure the bed hold policy is sent with the resident on discharge. This education was completed on May 3, 2019. c. A monitoring tool was developed to audit residents who are discharged/ transferred auditing that the bed hold policy was sent with the resident. d. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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F 625	Continued From page 103 1. Resident #24 was originally admitted to the facility on 10/13/18. The resident was readmitted on 01/11/19. Diagnosis for Resident #24 included but not limited to *End Stage Renal Failure (ESRD). *ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure). The current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 01/22/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments dated 01/08/19 - discharge return anticipated, resident readmitted on 01/11/19. On 01/08/19 at approximately 5:00 p.m., according to the facility's documentation, Resident #24 was administered Zofran for nausea. On the same day at 9:30 p.m., Resident #24, resident was throwing up blood (moderate) amount and still complaining of nausea. Resident #24 was transported to the local ER via Emergency Medical Services (EMS). An interview was conducted with License Practical Nurse (LPN) #3 on 04/03/19 at approximately 10:40 a.m. The surveyor asked, "What paperwork is sent with the resident when they are being sent out to the hospital." The nurse replied, "I send the resident's face sheet,	F 625	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 625	Continued From page 104 recent labs, progress note, POC, the order to send them out and their Do Not Resuscitate (DNR) Form." The surveyor asked, "Do you send a copy of the bed hold policy upon their discharge out to the hospital" The LPN stated, "I do not send a copy of the bed hold policy; I did not know I was suppose to." On 04/03/19 at approximately 10:43 a.m., an interview was conducted with LPN #4. The surveyor asked, "When you send a resident is sent out to the hospital for evaluation, do you send a copy of the bed hold policy upon their discharge?" The LPN replied, "No, I was not aware that we needed to send a copy of the bed hold policy." An interview was conducted with the facilities Regional Quality Specialist (RQS) on 04/04/19. The surveyor asked, "When a resident is being sent out the hospital, should the bed hold policy be sent with them upon discharge" she replied "Yes." The surveyor asked, "What is the purpose for sending the bed hold policy with them doing their discharge to the hospital. She said to let the resident and or representative know their bed is being held upon their return back to the facility." She said there was a conference call with the Administrator, Director of Nursing (DON) and Social Worker (SW) in November 2017, when the new regulation went into effect but was never implemented. The facility administration was informed of the finding during a briefing on 04/04/19 at approximately 6:05 p.m. The facility did not present any further information about the findings. 2. The facility's staff failed to provide written information to the resident or resident representative which specifies the duration of the	F 625		

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F 625	Continued From page 105 bed-hold policy upon transfer to the local psychiatric hospital on 1/7/19 for Resident #59. Resident #59 was originally admitted to the facility 6/14/18, and was readmitted to the facility 1/31/19, after a psychiatric hospital stay. The current diagnoses included; schizophrenia, hepatitis and renal insufficiency. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/12/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of 15. This indicated Resident #59's daily decision making abilities were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with eating and locomotion, limited assistance of one with bed mobility and transfers, extensive assistance of one person with toileting, and total care of one with dressing, personal hygiene and bathing. Review of the discharge MDS assessment dated 1/7/19, revealed Resident #59 was discharged-return not anticipated. Review of the clinical record revealed a nurse's note dated 1/7/19, at 5:00 p.m., which stated Resident #59 was admitted to a local psychiatric hospital for altered mental status. No documentation was included which stated the facility staff conveyed to the receiving providers the resident's summary of the comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer.	F 625		

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F 625	Continued From page 106 On 4/2/19 at approximately 2:30 p.m., the Unit Manager stated at the time of Resident 59's hospital transfer the facility staff was not aware of the requirement to provide written information to the resident or resident representative of the facility's bed-hold policy therefore; notification was not provided. 3. Resident #76 was discharged to the hospital on 02/08/2019 and the facility staff failed to provide the Resident and/or Resident Representative a written Bed Hold Notice. Resident #76 was discharged to the hospital on 02/08/2019 and readmitted to the facility on 02/20/2019. Diagnosis included but were not limited to, Diabetes Mellitus and Quadriplegia. Resident #76 ' s Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/27/2019 coded Resident #76 with short-term memory problems and longterm memory problems. In addition, the Minimum Data Set coded Resident #76 as requiring extensive assistance of 2 with bed mobility and toilet use, extensive assistance of 1 with dressing, eating and personal hygiene and total dependence of 1 with bathing. On 04/04/2019 at 12:00 p.m., an interview was conducted with the Social Worker and she was asked, "Can you provide proof that a Bed Hold notice was provided for Resident #76 upon discharge to the hospital?" The Social Worker stated, "The facility is not utilizing the Bed Hold policy on resident ' s upon discharge to the hospital." The administrative team was informed of the	F 625		

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F 625	Continued From page 107 finding on 04/04/2019 at approximately 6:00 p.m. No further information was provided about the finding. 4. The facility staff failed to ensure that Resident #368 received a written notice of the facility Bed-Hold policy upon transfer to the hospital on 09/10/18 on one closed record resident. Resident #368 was admitted to the facility on 01/20/17 and readmitted to the facility on 09/25/18 and discharged on 10/02/18. Diagnosis for Resident #368 included but not limited to Dementia and Anxiety Disorder. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 09/10/18. Staff assessment of mental status coded the resident as having short term memory problems. The Discharge MDS assessments was dated for 09/10/18-discharge return anticipated; re-admitted to the facility on 10/01/18. On 09/10/18, according to the facility's documentation, Resident #368 was transferred to the local hospital ER via 911 with diagnosis of hypernatremia. Two attempts were made to contact Responsible Party (RP). On 09/12/18 note states "This resident is at local hospital. Spoke to JFS (Jewish Family Services) case manager. On 04/03/19 Other Staff #8 was asked if a bed hold was offered to resident family and or representative. She stated there's no need to give resident a bed hold notice because there are always open beds available in the facility.	F 625		

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F 625	Continued From page 108 On 04/03/19 at approximately 7:00 PM, a notice of resident transfer or discharge was received from Other Staff #8, from admissions. The policy states as per admission agreement, the facility must transfer/discharge a resident when the facility determines that such action is appropriate in order to meet the resident's needs for healthcare services. An interview was conducted with the Minimum Data Set Coordinator (MDS) (Registered Nurse #1) on 04/04/19 at approximately 11:58 a.m., who stated, "We haven't been using the bed hold policy when residents are discharged to the hospital". An interview was conducted with License Practical Nurse (LPN) #8 on 04/04/19 at approximately 3:40 p.m., who stated, "They said that we weren't doing the bed hold policy" On 04/04/19 at approximately 5:30 PM a brief interview was conducted with the Administrator and Director of Nursing they were informed of the above findings. No comments were made. 5. The facility staff failed to provide Resident #119 with a written copy of the bed hold policy upon transfer to the hospital on 2/25/19. Resident #119 was a 77 year old admitted to the facility on 2/19/19 and was discharged on 2/25/19. Resident #119's diagnoses included but were not limited to *Type 2 Diabetes Mellitus, *Anxiety Disorder, and *Stage 3 Chronic Kidney Disease. The most recent Minimum Data Set (MDS) Assessment was a 5 day Discharge-return not	F 625		

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F 625	Continued From page 109 anticipated with an Assessment Reference Date (ARD) of 2/25/19. Resident #119's Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #119's Nurse's Notes were reviewed and are documented in part, as follows: 2/25/19 1PM: Upon further assessment it appears that resident is presenting with JVD (jugular vein distention), present on both sides of resident's neck. He continues to cough up sputum that is blood tinged. Unable to fully assess lung fields related to shallow breathing. MD (Medical doctor) notified. New order send resident to ED (emergency department) for further evaluation. Resident is self RP (responsible party) and aware. EMT's (emergency medical technicians) present for transfer to Name (hospital). Report given to ED. Resident currently enroute to ED. 2/25/19 8PM: Called placed to Name (hospital) stated patient will be admitted). Resident #119's Physician Orders were reviewed and are documented in part, as follows: 2/25/19 Patient may be sent out by 911. On 04/03/19 04:51 PM an interview was conducted with the Director of Nursing regarding what documentation is sent with a resident upon discharge to the hospital. The Director of Nursing stated, "I already told someone else I don't have knowledge about a bed hold or a care plan needing to be sent out with discharges. As far as I know the business office deals with the bed	F 625		

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F 625	Continued From page 110 holds the next day after our daily standup meeting." On 04/03/19 05:59 PM an interview was conducted with the Corporate Quality Specialist Nurse regarding care plans and bed holds being sent upon discharges. The Corporate Quality Assurance Nurse stated, "We were aware of the new regulations and we had a conference call with the CEO's and the DON's about 8 months ago to inform them of the changes." The facility policy titled "Bed-Holds and Returns" revised 3/2017 was reviewed and is documented in part, as follows: Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Policy Interpretation and Implementation: 3. Prior to a transfer, written information will be given to the residents and the resident representatives that explain in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer. On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared.	F 625		

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F 625	Continued From page 111 Prior to exit no further information was shared. 6. The facility staff failed to provide Resident #105 with written information of the facility's bed hold policy. Resident #105 was admitted to the facility 05/02/18 with diagnoses which included heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, end stage renal disease, and left below knee amputee. Resident #105 was sent out to the hospital on 2/12/19. A review of the clinical records did not indicate that Resident #105 was provided with written information regarding the facility's bed hold policy prior to this resident being transferred out to the hospital. A Minimum Data Set dated 3/16/19 assessed this resident has having a BIMS score of 11. This resident was assessed as having no hearing, speech or vision difficulty. A review of the clinical records indicated that on February 12, 2019, Resident #105 was admitted to the hospital for pneumonia and returned back to the facility on February 16, 2019. A review of the clinical records did not indicate that Resident #105 was provided with written information regarding the facility's bed hold policy prior to being transferred to the hospital. During an interview on 4/3/19 at 2:30 P.M. with the facility Social Worker, she stated, Resident #105 was not provided with a written notice of the facility's bed hold policy prior to being transferred to the hospital.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 112 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, clinical record review, and review of the facility's policy, the facility staff failed to complete discharge Minimum Data Set (MDS) assessments for two of 51 residents (Resident #1 and 268), in the survey sample. 1. The facility staff failed to complete a discharge MDS assessment for Resident #1's discharge to the community, 12/20/18. 2. The facility staff failed to complete a discharge MDS assessment for Resident #268's discharge to another nursing home, 2/19/18. The findings included: 1. Resident #1 was admitted to the facility 11/10/18 and was discharged from the facility to the community on 12/20/18. The diagnoses at the time of discharge included heart failure, dementia and diabetes. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. Review of Resident #1's MDS assessments didn't reveal a discharge MDS assessment dated	F 641	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #1 and #268 MDS discharge assessments were completed 4/3/19. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who are discharged from the facility have the potential to be affected by the deficient practice.	

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F 641	Continued From page 113 12/20/18, therefore an interview was conducted with the MDS Coordinator on 4/3/19 at approximately 12:10 p.m. The MDS Coordinator stated the discharge MDS had not been completed but it would be completed shortly. Resident #1's discharge MDS assessment was completed 4/3/19. A completed discharge assessment for Resident #1 was presented on 4/4/19 at approximately 6:25 p.m. It was dated 4/3/19. 2. Resident #268 was admitted to the facility 1/25/18 and was discharged to another nursing home 2/19/18. The diagnoses at the time of discharge included high blood pressure and depression. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/31/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #268's cognitive abilities for daily decision making were intact. Review of Resident #268's MDS assessments didn't reveal a discharge MDS assessment dated 2/19/19, therefore; an interview was conducted with the MDS Coordinator on 4/3/19 at approximately 12:10 p.m. The MDS Coordinator stated the discharge MDS had not been completed but it would be completed. Resident #268's discharge MDS assessments was completed 4/5/19. A completed discharge assessment for Resident #268 was presented 4/5/19 at approximately 1:30 p.m. It was dated 4/5/19.	F 641	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. An audit of all residents who had been discharged from the facility from December 2018 to April 8, 2019 was completed ensuring an MDS discharge assessment had been completed. Any found to be out of compliance were corrected at that time. b. The MDSC was in-serviced by the Director of Nursing or Assistant Director of Nursing on the MDS Assessment – RAI Policy emphasizing that a discharge assessment will be completed on all residents who are discharged from the facility and that the RAI manual will be followed for transmitting assessments. This education was completed on May 3, 2019. c. The MDS Assistant was in-serviced on 4/5/19 by the Regional Quality Specialist over the MDS Assessment – RAI Policy emphasizing that a discharge assessment will be completed on all residents who are discharged from the facility and that the RAI manual will be followed for transmitting assessments. d. A monitoring tool was developed that is to be brought into the clinical meetings to track all discharged residents and the date the MDS discharge assessments were completed. e. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 641	Continued From page 114 On 4/5/19, at approximately 2:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate quality Assurance Specialist. The Director of Nursing stated the expectation was for MDS assessments to be completed per CMS timeframes. The facility's policy titled "MDS Completion and Submission Timeframes" dated 7/2019 read: the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.	F 641	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **(5) Completion Date: 5/17/19**	
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability	F 645	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Residents #19, # 78, #112 and #81 did not have a PASSR completed at the time of admission. b. These PASSR'S were completed by the Social Services Director in accordance with the Medicaid Memo that we received in November of 2018. #19– PASSR completed 4/2/19 #78 – PASSR completed 4/2/19 #112 – PASSR completed 3/20/19 #81 – PASSR completed 10/24/18 **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents admitted to the facility have the potential to be affected.	

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F 645	Continued From page 115 authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an	F 645	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. Admissions Director, Business Office Manager, and Social Services Director were re-educated on the Policy and Procedures for PASSR's by the Regional Quality Specialist on 4/5/19. b. When a resident is being admitted to the facility before they arrive a PASSR will be completed either by the previous facility/hospital or by the Admissions Director. c. Copy of the PASSR will be placed in the medical record and in the resident's financial file. d. Tracking tool was created to ensure all current residents have a PASSR. Residents who have been identified without a PASSR, the Social Services Director will complete the PASSR prior to the deadline of 4/16/19. e. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed.	

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F 645	Continued From page 116 intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff failed to ensure a level I PASARR screening was completed before admission or within thirty days after admission on four residents out of a survey sample of 51 Residents. Residents #19,#78, #112, and #81. 1. The facility staff failed to ensure that a Level I PASARR was completed for resident #19. 2. The facility staff failed to ensure a PASARR was completed for Resident #112. 3. The facility staff failed to provide Resident #81 with a Level I PASARR screening prior to admission. 4. The facility staff failed to ensure a PASARR was completed for Resident #78. The findings included: 1. Resident #19 was originally admitted to the facility on 04/26/18. Diagnoses for Resident #19 Anxiety Disorder, Major Depressive Disorder and Dementia. The Admission Minimum Data Set with an assessment reference date of 05/04/18, coded Resident #19 with a score of 08 out of possible 15 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment.	F 645	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Admissions Director will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 05/17/2019**	

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F 645	Continued From page 117 On 04/02/19 the Social Worker was asked for a copy of Resident #19's Level I PASARR screening. A review of the Level I PASARR screening showed the screening was completed on 04/02/19 by the social worker. A review of Level I PASARR screen dated after Resident's admission to the facility, stated no referral for PASARR II. On 04/04/19 at approximately 5:11 PM, a brief interview was conducted with Social worker, (Other staff #1) concerning Resident #19's Level I PASARR screening. She was asked what should have been done concerning the Resident #19's PASARR screening? She stated that ideally, the Level I PASARR "should be completed prior to admission or at least 30 days after admission." On 04/04/19 at approximately 5:30 PM the Administrator and Director of Nursing were informed of the above findings. No comments were made. 2. The facility staff failed to ensure a PASARR was completed for Resident #112. Resident #112 was admitted to the facility on 11/02/15 and readmitted on 12/20/18. Diagnoses for resident #112 included Dementia, Major Depressive Disorder, Unspecified Psychosis. The Annual Minimum Data Set (MDS) assessment with an assessment reference date of 09/27/18, coded Resident #112 with a score of 07 out of possible 15 on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment.	F 645		

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F 645	Continued From page 118 On 04/02/19 the Social Worker was asked for a copy of Resident #112 Level I PASARR screening. A review of the Level I PASARR screening showed the screening was completed on 03/20/19 by the social worker. A review of Level I PASARR Screen stated No referral for PASARR II. Does not meet the applicable criteria for serious MI or ID or related condition. On 04/04/19 at approximately 5:11 PM, an interview was conducted with Social worker, (Other staff #1) concerning Resident #112's Level I PASARR screening. She was asked what should have been done concerning Resident #112's PASARR screening? Other staff #1 stated that ideally, the Level I PASARR "should be completed prior to admission or at least 30 days after admission." On 04/04/19 at approximately 5:30 PM the Administrator and Director of Nursing were informed of the above findings. No comments were made. 3. The facility staff failed to ensure Resident #81 was screened for a mental disorder or intellectual disability prior to admission. Resident #81 was admitted to the facility on 2/19/19 with diagnoses of vascular dementia without behavioral disturbance, cardiovascular disease, cognitive communication deficit, hard of hearing, anxiety and irritability during the day. The facility staff failed to provide a Preadmission Screening and Resident Review (PASARR) to assess the need of Resident #81 for a mental disorder or intellectual disability prior to	F 645		

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F 645	Continued From page 119 admission. An Initial Minimum Data Set (MDS) dated 2/28/19 assessed Resident #81 in the area of hearing and speech as having minimal difficulty in some environments. In the area of Cognitive Patterns this resident had a BIMS score of 9 which indicated moderate cognitive impairment. In the area of Functional Status the resident was assessed in the area of eating as independent-no help or staff oversight at any time. This resident had no issues with standing, walking, range of motion or balance. A Care Plan dated 3/5/19 indicated: Problem/Need- Resident #81 has a cognitive deficit due to diagnoses of dementia; Goal-Resident needs will be met daily; Approaches- address resident by name, identify self and position with resident, maintain consistent environment and provide daily routine. Problem- resident has a potential for falls due to unsteady gait-uses walker for ambulation, poor safety awareness; Goal- resident will have no injury from falls; Approaches-keep room and pathway free of clutter, report any change in gait/balance when walking and encourage rest periods. During an interview on 4/3/19 at 2:50 P.M. with the facility Social Worker, she stated, Resident #81 was not provided with a Level I PASARR screening prior to admissions. The facility staff failed to provide Resident #81 with a Level I PASARR screening prior to admissions. 4. For Resident #78, facility staff failed to ensure a PASARR was completed.	F 645		

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F 645	Continued From page 120 Resident #78 was admitted to the facility on 9/3/11 and readmitted on 2/7/17 with diagnoses that included but were not limited to Bipolar two disorder, high blood pressure and epilepsy. Resident #78's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/26/19. Resident #91 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #78's most recent comprehensive MDS (minimum data set) assessment was an annual assessment with an ARD of 6/19/18. Resident #78 was coded in Section A1500-Preadmission Screening and Resident Review, as not being currently considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. Review of the clinical record failed to evidence a Preadmission Screening and Resident Review having been completed. On 4/3/19 at 1:03 p.m., an interview was conducted with OSM (other staff member) #1, the social worker. When asked the process of obtaining a PASARR, OSM #1 stated that she was just given the responsibility this year (2019)to obtain PASARRs. OSM #1 stated that the facility had previously obtained PASARRs from the residents' previous nursing facility or the hospital. OSM #1 stated that the facility did an audit last month on residents who needed PASARRs. OSM #1 stated that Resident #78 must have been missed. When asked the purpose of the	F 645		

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F 645	Continued From page 121 PASARR, OSM #1 stated that the purpose was to determine the need for nursing facility placement for long term care. OSM #1 presented Resident #78's PASARR completed 4/2/19, completed after it was requested by this writer. Resident #78 did not meet the criteria for a level 2 PASARR. On 4/5/19 at 9:30 a.m., ASM (administrative staff member) #1, the CEO (Chief Executive Officer) and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled "Preadmission Screening and Resident Review Process" documents in part, the following: "This process is conducted to ensure that individuals are placed appropriately, in the least restrictive setting possible, and that individuals receive care and services wherever they are living. The process involves two steps, known as Level I and Level II screening and evaluation. By federal law, an individual shall not be admitted to a NF (Nursing facility) unless a level 1 screening has been completed, and, if it is determined that the individual has a condition of MI/ID or RC, then the individual shall not be admitted until the Level II evaluation and determination has been completed."	F 645		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		

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F 657	Continued From page 122 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record reviews the facility staff failed for six residents (Resident #76, Resident #106, #103, #51, #373, #69) out of 51 residents in the survey sample to ensure the comprehensive care plan was revised based on changing goals, preferences and needs of the resident. 1. The facility staff failed to revise Resident #76's comprehensive care plan to include the wound on his right heel. 2. The facility staff failed to revise Resident #106's comprehensive person centered care plan to include at risk for elopement. 3. The facility staff failed to review and revise	F 657	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #76, #103, #106, #66, #373, and #69 had their care plans updated to reflect omissions on April 18, 2019. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents have the potential to be affected by the deficient practice.	

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F 657	Continued From page 123 Resident #103's care plan to include non-slip sock while in bed based on the root cause of an investigation of a right fractured clavicle on 1/20/19. 4. For Resident #66, facility staff failed to revise the care plan after an allegation of sexual abuse was reported to social services on 05/15/18 and the staff member was reassigned to a different unit. 5. For Resident #373, facility staff failed to revise the care plan when he arrived back from the hospital with a right clavicle fracture on 2/2/19. 6. The facility staff failed to assure Resident #69's care plan was revised to include a right buttock wound. The findings included: 1. Resident #76 was readmitted to the facility on 02/20/2019. Diagnoses included but were not limited to, Diabetes Mellitus and Quadriplegia. Resident #76's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 02/27/2019 coded Resident #76 with short-term memory problems and long-term memory problems. In addition, the MDS coded Resident #76 as requiring extensive assistance of 2 with bed mobility and toilet use, extensive assistance of 1 with dressing, eating and personal hygiene and total dependence of 1 with bathing. On 04/04/2019 at 10:03 a.m., wound care to an open wound (Stage II) was observed on Resident #76's right heel. No information was in the resident's care plan pertaining to the wound on	F 657	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. An audit of all current residents care plans was completed by MDS on April 26, 2019 ensuring all care plans contained accurate and up to date information. b. The MDSC and MDS assistant were in-serviced by the Director of Nursing or Assistant Director of Nursing on the Comprehensive Care Plan Policy and Procedure emphasizing that the resident's care plan should be up to date reflecting any changes, interventions, or preferences of the resident. This education was completed on April 26, 2019. c. A monitoring tool was developed to track care plan accuracy as changes occur. The monitoring tool will be brought to the clinical meetings for review by Nursing Administration. d. Care plans will be updated during the clinical meetings as resident changes are being reviewed. e. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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F 657	Continued From page 124 the right heel. On 04/04/2019 at approximately 1:30 p.m., an interview was conducted with the Assistant MDS Coordinator. She was told that wound care was observed on Resident #76's right heel however no information was located in the resident's care plan pertaining to the wound. The Assistant MDS Coordinator stated, "I will review the care plan and get back to you." On 04/04/2019 at approximately 5:00 p.m., the Assistant MDS Coordinator stated, "I spoke with the nurses on the unit this afternoon and they informed me that when the resident was readmitted to the facility on 02/20/2019 that he had a closed scabbed area on his right heel." The Assistant MDS Coordinator stated, "I reviewed the care plan and realized that the care plan had not been revised to include the wound on the right heel." The MDS Coordinator also stated, "The nurses are now treating the area with a different treatment since the area is open." The Surveyor asked the MDS Coordinator, "Was the care plan updated after the area opened up?" The Assistant MDS Coordinator stated, "No." The Surveyor asked the Assistant MDS Coordinator, "Who revises the care plans?" The Assistant MDS Coordinator stated, "The MDS Coordinators revise the care plans." The Assistant MDS Coordinator was asked, "What is the purpose of the care plan?" The Assistant MDS Coordinator stated, "To help staff take good care of the resident." The Assistant MDS Coordinator was asked, "Should the care plan have been revised to include the residents wound on his right heel?" The Assistant MDS Coordinator stated, "Yes." The Assistant MDS Coordinator stated, "I will update the care plan to	F 657	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 657	Continued From page 125 include the wound on the right heel." The administrative team was informed of the finding on 04/04/2019 at approximately 6:00 p.m. No further information was provided about the finding. 2. Resident #106 was originally admitted to the nursing facility on 01/09/19. Diagnoses for included but not limited to *Dementia without behavioral disturbance. Resident #106's MDS a quarterly assessment with an Assessment Reference Date (ARD) of 03/19/19 coded resident with a BIMS score of 01 indicating severe cognitive impairment. Under section, G0600 (mobility devices) was coded for the use of a wheelchair. In addition, the MDS under section G (functional status) was also coded for supervision-oversight encouragement or cueing with locomotion on and off the unit. During the initial facility tour on 04/01/19 at approximately 6:09 p.m., Resident #106 was observed with a wander guard bracelet to his right ankle. The review of Resident #106's physician order dated 03/21/19 include the following order: Place wander guard related to exit seeking. The review of the Resident #106's comprehensive care plan did not include at risk for elopement. An interview was conducted with the MDS Coordinator on 04/02/19 at approximately 4:33 p.m. She said Resident #106 does wander around the facility in his wheel chair but has never had an elopement behavioral. The surveyor	F 657		

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F 657	Continued From page 126 reviewed the nurse's note written on 03/21/19 with the MDS Coordinator. The note read: wander guard placed on right ankle of Resident #106 related to resident attempting to exit facility at main entrance; staff redirected resident. The MDS Coordinator replied, "I missed that one." On 04/03/19 at approximately 3:10 p.m., the MDS Coordinator gave the surveyor an elopement care plan dated 04/02/19 to include the following problem: Resident #106 is at risk for elopement by history of resident wandering aimlessly, impaired safety awareness r/t diagnosis of dementia. The goal: Resident should remain safe with no incidence of elopement daily. Some approaches to manage the goals included: utilize and check wander guard placement as indicated, redirect resident from exit doors and make sure all staff are aware of the resident's elopement risk. An interview was conducted the Assistant MDS Coordinator on 04/04/19 at approximately 10:05 a.m., who stated, "The MDS Coordinator, myself as well as the nurses are responsible for updating the resident's care plan." She said the purpose of a residents person centered care plan is to show how the resident is being taken care of, so staff knows what is currently going on with the resident related to their care and any type of behaviors. She said the wander guard bracelet should have been care planned, resident #106 is an elopement risk. The facility administration was informed of the finding during a briefing on 04/04/19 at approximately 6:05 p.m. The facility did not present any further information about the finding.	F 657		

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F 657	Continued From page 127 Definitions: *Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm). 3. The facility staff failed to review and revise Resident # 103's care plan to include non-slip sock while in bed based on the root cause of an investigation of a right fractured clavicle on 1/20/19. Resident #103 is a 94 year old admitted to the facility on 3/19/18 with diagnoses to include but not limited to Alzheimer's Disease, Major Depressive Disorder and Falls. Resident #103's most recent Minimum Data Set (MDS) assessment was an Annual assessment with an Assessment Reference Date (ARD) of 3/19/19. Resident #103's Brief Interview for Mental Status (BIMS) indicated that the resident was rarely or never understood, had short and long term memory recall issues and was severely cognitively impaired for daily decision making. Resident #103's Nurse's Notes were reviewed and are documented in part, as follows: 1/20/19 8 AM: Notified by CNA (Certified Nursing Assistant) resident have bruising to R (right) shoulder when she touched her arm. Pt. (patient) express pain. Pt. assess right shoulder bruising , red in color, swelling and warm to touch. Pt. express pain with touch stimuli. MD (medical	F 657		

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F 657	Continued From page 128 doctor) notified new order X-ray right shoulder. RP (responsible party) made aware. Tylenol 2 tabs 650 mg(milligrams) given for pain. Mobilex notified, awaiting x-ray tech. 1/20/19 12 PM X-ray tech rendered care. Awaiting x-ray results. 1/20/19 3:30 PM: MD made aware of x-ray results. N.O. (new order) send to ER (emergency room) for evaluation and treatment. RP made aware. Resident #103's physician orders were reviewed and are documented in part, as follows: 1/20/19: Medication Order-Right shoulder X-ray two views. Indication/Diagnosis- Right shoulder bruise, swelling, pain. 1/20/19: Medication Order-Send to ER for evaluation and treatment. Indication/Diagnosis- Distal right clavicle fracture. Resident #103's Radiology Report dated 1/20/19 at 12:52 PM was reviewed and is documented in part, as follows: Results: There is a displaced fracture of the distal right clavicle. No significant callus formation noted and the fracture appears recent. Conclusion: Displaced distal right clavicle fracture. Fax time stamp at top of the radiology report to the facility was 1/20/19 at 12:55 PM. Resident #103's Emergency Room	F 657		

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F 657	Continued From page 129 documentation dated 1/20/19 was reviewed and is documented in part, as follows: Diagnosis: Closed displaced fracture of acromial end of right clavicle. ED (Emergency Department) Notes/Significant Events Notes: Pt. (patient) arrived by rescue from Name (facility) for a broken RIGHT clavicle per x-rays; staff was unable to tell rescue what caused fracture. ED Attending Supervision Note: 93 year old female sent from nursing home for broken clavicle. Altered at baseline per family. Trauma unwitnessed, unknown if fell. Resident#103's Facility Reported Incident (FRI) dated 1/21/19 was reviewed and is documented in part, as follows: Report date: 1/21/2019 Incident date: 1/20/2019 Injuries: Yes, Fracture to right clavicle. Incident Type: Injury of unknown origin. Describe incident, including location,and action taken: Right shoulder noted with bruising, swelling and painful to touch by CNA who reported her observation to LPN (Licensed Practical Nurse). Physician was notified and ordered an x-ray. results of x-ray obtained showing a right clavicle fracture. Orders to send resident to ER and returned to facility at 11:45 PM. If applicable, date notification provided to: Responsible Party: 1/20/19 Physician: 1/20/19 APS(Adult Protective Services): 1/21/19	F 657		

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F 657	Continued From page 130 Fax time stamp at top of the FRI report to the Office of Licensure and Certification was 1/21/19 at 16:25(4:25) PM. The facility's 5 Day Investigation for Resident #103's serious bodily injury of unknown origin dated 1/23/19 was reviewed and is documented in part, as follows: Summary: After reviewing all witness statements and receiving the resident interview by Social Services I conclude that the injury of unknown injury was as a result of Name (Resident #103) falling between the hours of 11:00 PM to 7:00 AM. Action: *Based on the root cause of the investigation non-slip socks will be worn by Name (Resident #103) while in bed. *Care Plan has been updated for the non-slip socks. Resident #103's Current Comprehensive Care Plan dated 3/19/19 was reviewed and under potential for fall related to poor safety awareness and adverse effects from medications there was no intervention listed to include that non-slip socks will be worn while in bed. On 4/3/19 at 2:11 PM an interview was conducted with the MDS Coordinator regarding Resident #103's current Comprehensive Care Plan dated 3/19/19. The MDS Coordinator was asked to review the care plan and asked if the plan included non-slip socks to be worn while in bed for Resident #103 as an intervention for falls. The MDS Coordinator stated, "No, it is not on there,"	F 657		

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F 657	Continued From page 131 On 04/03/19 05:00 PM an interview was conducted with the Administrator regarding his investigation of Resident #103's fractured clavicle to include the staff statements and who was instructed to update the resident's plan of care to include non-skid socks. The Administrator stated, "I can't find the staff statements that were done with the initial investigation, they (the staff members) are all still here I can have them rewrite them. I told Name (MDS Coordinator) to update the care plan regarding the non skid socks." On 04/03/19 05:30 PM an interview was conducted with the MDS Coordinator. The MDS Coordinator was asked if the Administrator had instructed her to update Resident #103's care plan to include non-skid socks while in bed after the investigation of the injury of unknown origin on 1/20/19. The MDS Coordinator stated, "If he said he told me to do it then he probably did, but I must have forgotten to do it. I will update her care plan right now." The facility policy titled "Care-Plans, Comprehensive Person-Centered" last revised 12/2016 was reviewed and is documented in part, as follows: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 13. Assessments of residents are ongoing and	F 657		

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F 657	Continued From page 132 care plans are revised as information about the residents and the residents' conditions change. On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared. The Director of Nursing stated, "Each morning during the standup meeting we discuss and changes with the residents. Name (MDS Coordinator) takes the information from standup and updates the care plans." Prior to exit no further information was shared. 4. For Resident #66, facility staff failed to revise the care plan after an allegation of sexual abuse was reported to social services on 5/15/18 and the staff member was reassigned to a different unit. Resident #66 was admitted to the facility on 10/11/13 and readmitted on 7/24/14 with diagnoses that included but were not limited to major depressive disorder, type two diabetes mellitus, and cerebrovascular disease. Resident #66's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/19/19. Resident #66 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded as requiring one person physical assist with bathing. On 3/20/19 a complaint was submitted to the OLC (Office of Licensure and Certification) regarding sexual abuse between a CNA (certified nursing assistant) and Resident #66.	F 657		

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F 657	Continued From page 133 On 4/2/19 at 10:16 a.m., an interview was conducted with Resident #66. Resident #66 denied any abuse from staff members. Resident #66 declined further interview and asked this writer to leave her room. Review of Resident #66's clinical record revealed that she had filed a grievance with the social worker on 5/15/18. The following was documented by the social worker: "Describe concern in detail: CNA(certified nursing assistant) (Name of CNA #16) made her uncomfortable during shower. said (sic) "I'll wash your back if you wash my back." Was not using washcloth to wash her back-did not want him to use bare hands. Staff member assigned responsibility for the investigation: (Name of CEO (Chief Executive Officer)), Assigned by SS (Social Services). Date assigned: 5/15/18. Findings of investigation: Spoke to (Name of CNA #16) at 3:00 PM on 5-16-18 concerning the care given during a shower to resident. He stated that he did shower resident and was using gloves. He denied saying "I'll wash your back if you wash my back."' Plan to resolve complaint/grievance: (Name of CNA #16) will use a washcloth and gloves during care. 2 Warned that comments as described would not be tolerated." Results of actions taken: Spoke with (Name of Resident #66) and told her that (Name of CNA #16) will use gloves and washcloth during care." Review of the staff sheets dated 5/2018 through 6/2018 revealed that CNA #16 was reassigned after this incident to a different unit. Review of the staff sheets from the last three months revealed that CNA #16 identified had not been working with Resident #66.	F 657		

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F 657	Continued From page 134 Review of Resident #66's comprehensive care plan dated 2/21/19 failed to evidence this allegation of sexual abuse. On 4/3/19 at 6:28 p.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS nurse. When asked the purpose of the care plan, LPN #6 stated that the care plan is a book for each resident that guides the resident's care. LPN #6 stated that care areas such as ADL (activities of daily living) and diagnoses would be on the care plan to help staff better care for the resident. When asked if it was important for the care plan to be accurate, LPN #6 stated that it was. When asked who was responsible for revising the care plan, LPN #6 stated that the MDS coordinator updates the care plan. LPN #6 stated that unit managers can also revise the care plan. LPN #6 stated that the care plan was revised for any changes in the resident's condition or care. On 4/4/19 at 9:27 a.m., further interview was conducted with LPN (licensed practical nurse) #6, the MDS nurse. When asked if the residents' care plan should be revised if they reported an allegation of abuse from a staff member and are no longer receiving care from that staff member, LPN #6 stated, "We don't tolerate that. I don't think that staff member would be here. That wouldn't be in the care plan. We don't put staff members name in the care plan." When asked how staff would know to monitor a resident's mood/emotional status after an allegation of abuse if it is not documented in the care plan, LPN #6 stated that the unit manager could pass that information along to staff after the situation is discussed in the daily morning meeting. When	F 657		

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F 657	Continued From page 135 asked if it should be documented in the care plan that the resident has a history of being abused or alleged abuse, LPN #6 stated, "We could if the resident is extra sensitive or self conscious about abuse." LPN #6 stated that if a resident is no longer to receive care from a staff member, that information would also be passed on from the unit manager to floor staff. On 4/4/19 at approximately 9:35 a.m., an interview was conducted with CNA (certified nursing assistant) #2, Resident #66's nursing aide. When asked if there was a staff member that cannot work with Resident #66, CNA #2 stated that she was not aware of any staff member that could not work with Resident #66. CNA #2 also stated that she floated to different units and did not work on her current assignment too often. On 4/4/19 at approximately 9:41 a.m., an interview was conducted with LPN #14, Resident #66's nurse. When asked if there was a staff member that cannot work with Resident #66, LPN #14 stated that she was not made aware until that morning that Resident #66 could not have the above male CNA. LPN #14 stated that she didn't even know who the male CNA was. LPN #14 stated that she was made aware by the social worker. LPN #14 stated that she worked with Resident #66 on a full time basis, 7-3 shift. On 4/5/19 at 9:30 a.m., ASM (administrative staff member) #1, the CEO (Chief Executive Officer) and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. 5. For Resident #373, facility staff failed to revise the care plan when he arrived back to the hospital	F 657		

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F 657	Continued From page 136 with a right clavicle fracture on 2/2/19. Resident #373 was admitted to the facility on 9/21/17 and readmitted on 2/2/19 with diagnoses that included but were not limited to pneumonia, hemiplegia (left sided paralysis) post stroke, and right clavicle fracture. Resident #373's most recent comprehensive MDS (minimum data set assessment) was a reentry assessment with an ARD (assessment reference date) of 2/12/19. Resident #373 was coded as being severely impaired in the ability to make daily decisions scoring 2 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #373 passed away on 3/22/19 and is no longer a resident of the facility. On 3/20/19 a complaint was submitted to the OLC (Office of Licensure and Certification) regarding Resident #373 right clavicle fracture. Review of Resident #373's nursing notes revealed that Resident #373 had been transferred to the hospital due to critical laboratory tests on 1/26/19. The following note was written: "1/26/19 Critical Labs results called to (Name of physician. Order received to send resident out for blood transfusion." Review of Resident #373's emergency room report documented the following: Chief Complaint: low hgb (hemoglobin) (1). Patient is a 80 year old male with hx (history) of CVA (cerebrovascular accident) with L(left) hemiplegia and dysphagia (difficulty swallowing) (wheelchair bound. s/p (status post) PEG (peg tube), seizures...who presents from SNF (skilled nursing facility) for low hgb, was 5.7 yesterday. Advised to go to ER (emergency room)...C/O (complaints) R	F 657		

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 657	Continued From page 137 (right) shoulder/back pain. Fell out of wheelchair 2 weeks ago. Having pain since. Able to move arm ok." Further review of the hospital records revealed that an x-ray was conducted on 1/27/19 showing a right clavicle fracture. Review of Resident #373's nursing notes revealed that Resident #373 had a fall on 1/11/19. No injuries were documented. There was no additional evidence to show that Resident #373 had any signs or symptoms of further injury or increased pain before his transfer to the hospital. Resident #373 was readmitted to the facility on 2/2/19 with a diagnosis that included but was not limited to right clavicle fracture. Resident #373's significant change MDS with an ARD of 2/12/19 documented Resident #373 as having a fracture. Resident #373 had the following physician orders on 2/3/19: "Add to POS (physician order summary): Dx (diagnosis) of (R) clavicle fx (fracture)...No forward flexion or abduction greater then 90 degrees at right shoulder. ROM (range of motion) as tolerated to (R) elbow, wrist, and hand. May have sling as needed for comfort to RUE (right upper extremity)..." Review of Resident #373's comprehensive care plan dated 2/19/19, failed to evidence care for his right clavicle fracture. On 4/3/19 at 6:28 p.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS nurse. When asked the purpose of the care plan, LPN #6 stated that the care plan is a book for each resident that guides the resident's	F 657		

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F 657	Continued From page 138 care. LPN #6 stated that care areas such as ADL (activities of daily living) and diagnoses would be on the care plan to help staff better care for the resident. When asked if it was important for the care plan to be accurate, LPN #6 stated that it was. When asked who was responsible for revising the care plan, LPN #6 stated that the MDS coordinator updates the care plan. LPN #6 stated that unit managers can also revise the care plan. LPN #6 stated that the care plan was revised for any changes in the residents condition or care. On 4/4/19 at 9:27 a.m., further interview was conducted with LPN (licensed practical nurse) #6, the MDS nurse. When asked if she would expect the care plan to be revised if a resident were to obtain a new fracture, LPN #6 stated that if the resident was going to physical therapy and had orders regarding the care for the fracture, she wouldn't necessarily expect to see the fracture on the care plan. When clarified what LPN #6 stated on 4/3/19 regarding the care plan reflecting the care for the resident, LPN #6 stated that the care plan contains anything pertinent or significant to the resident's care. When asked if a clavicle fracture is pertinent/significant to the resident's care, LPN #6 stated that she would go find out. LPN #6 agreed that she did not see Resident #373's fracture on his care plan. LPN #6 did not come back to answer the above care plan question. On 4/5/19 at 9:30 a.m., ASM (administrative staff member) #1, the CEO (Chief Executive Officer) and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. (1) Hemoglobin (Hb) is the protein contained in	F 657		

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F 657	Continued From page 139	F 657		

red blood cells that is responsible for delivery of oxygen to the tissues. To ensure adequate tissue oxygenation, a sufficient hemoglobin level must be maintained. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK259/.
6. The facility staff failed to assure Resident #69's care plan was revised to include a right buttock wound.

Resident #69 was originally admitted to the facility 5/3/11 and readmitted 4/24/15, after admission to a local acute care hospital. The current diagnoses included; stroke, hemiparesis, diabetes, depression and moisture associated skin damage.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/19/19 coded the resident as not completing the Brief Interview for Mental Status (BIMS) therefore the staff interview revealed the resident was with long term and short term memory problems and severely impaired decision making abilities. In section "G" (Physical functioning), the resident was coded as requiring extensive assistance of 2 people with transfers, extensive assistance of 1 person with bed mobility, dressing, toileting, personal hygiene, eating and bathing.

The physician order summary revealed an undated order which read; right buttock-clean wound with dermal wound cleanser, pat dry, apply Santyl to wound bed, then Alginate and cover with dry dressing daily and as needed.

The active care plan dated 2/19/19, revealed a problem which read; (name of resident) has a

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F 657	Continued From page 140 potential for alteration in skin integrity/breakdown, other than pressure ulcers like abrasion, bruises, rashes, skin tears, cuts, etc. The goal read; maintain intact skin integrity by next review 5/26/19. The interventions included; If alteration in skin integrity occurs, notify the nurse immediately. Follow physician orders for treatment. Use proper technique when lifting and repositioning resident. Do not pull or slide resident in bed to prevent skin friction. On 4/2/19, at approximately 11:45 a.m., Resident #69's right buttock wound care was observed. The wound care was provided by Licensed Practical Nurse (LPN) #10 assisted by Certified Nursing Assistant (CNA) #13. Resident #69 was observed with a 6 centimeter by 3 centimeter open wound to the right buttock. The right buttock wound contained approximately 40% slough and appeared to tunnel at three o'clock. An interview was conducted with the LPN MDS Coordinator on 4/4/19 at approximately 4:00 p.m. She stated the care plan didn't reflect Resident #69 current skin integrity status and she would update the care plan. On 4/4/19, at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate quality Assurance Specialist. The Director of Nursing stated the expectation is for the care plan to reflect the resident's current status. She stated the opportunity to gain the information is presented at daily stand-up and stand-down meetings as well as the weekly standards of care meeting. The DON stated once the information is gained the MDS Coordinators are expected to update the care plan.	F 657		

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F 657	Continued From page 141 The facility's policy titled "Care Plans, Comprehensive Person-Centered" dated 12/2016 read; at#14 The Interdisciplinary Team must review and update the care plan: when there has been a significant change in the resident's condition. When the desired outcome is not met. When the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. Complaint Deficiency. 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 a complaint investigation, clinical record review, staff and resident interviews and facility documentation review, the facility staff failed to accurately assess areas of skin breakdown and provide appropriate interventions, care and treatment which constituted harm for	F 657		
F 686 SS=G		F 686	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. The resident identified was discharged to the hospital. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who have skin issues have the potential to be affected by the deficient practice.	

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F 686	Continued From page 142 one resident (Resident #369) in the survey sample. 1. The facility staff failed to accurately assess Resident #369 for a sacral pressure ulcer. Upon assessment in the local ER, the resident was assessed to have an unstageable sacral pressure ulcer 9.5 centimeters (cm) x 8.5 cm x 0.0 depth with yellow slough wound bed, which constituted harm. The findings included: Resident #369 was admitted to the nursing facility on 2/6/18 with diagnoses that included acute and chronic renal failure, fungal urinary tract infection, bladder outlet obstruction, benign prostatic hypertrophy, diabetes, Parkinson's disease, dementia, high blood pressure and gastroesophageal reflux disease. The resident was discharged to the local hospital on 10/3/18 and did not return to the nursing facility. Resident #369's Minimum Data Set (MDS) assessment dated 6/21/18 was a quarterly and coded the resident with a 9 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the skills needed for daily decision making. The residents was assessed to require extensive assistance of two staff for bed mobility, transfers, toilet use and bathing. The resident was not able to stabilize himself without staff assistance to ambulate and used a wheelchair for main mode of mobility. The resident was coded to be at risk for the development of pressure ulcers, but had none upon admission to the nursing facility. The assessment was coded for other skin problems	F 686	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. A skin audit was completed on all current residents on April 10, 2019 by Nursing Administration for any skin issues. Any concerns identified were ensured to have a treatment in place and added to the wound report for tracking progress until resolution. b. The Director of Nursing and Assistant Director of Nursing were in-serviced by the Regional Quality Specialist on 4/16/19 over Pressure Ulcers and Non-Pressure Wounds emphasizing tracking the progression and rounding on wounds in the facility. c. All Licensed Nurses and Certified Nursing Assistants were in-serviced by the Director of Nursing or Assistant Director of Nursing over the Pressure Ulcer Risk Assessment and Prevention of Pressure Ulcer Policies. Emphasis was placed on prevention of skin issues and reporting any issues identified. Nursing will ensure the MD/RP has been notified, a treatment has been put in place, and that the wound has been added to the wound report for tracking until resolution. This education was completed on May 3, 2019. d. Nursing Administration will follow up ensuring there is a treatment in place and the wound identified has been added to the wound report for tracking during the next clinical meeting.	

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F 686	Continued From page 143 as well as wound infections other than feet. Resident #369 was assessed always incontinent of bowel and bladder. The care plan dated 2/19/18 identified the resident had a potential for pressure ulcers and alteration in skin integrity other than pressure ulcers. The goal the staff set for the resident was that his skin would remain intact by the next review, 5/19/18. Some of the approaches the staff would implement to accomplish this goal included use proper technique when lifting and repositioning, do not pull or slide resident in bed, dietary to ensure necessary calories and call physician for any treatment orders. This care plan problem listed a right buttock boil and treatment as ordered to include an oral antibiotic, but there was no date to indicate when the boil originated. A care plan dated 6/28/18 identified an actual skin alteration-right buttock abscess. The goal set by the staff for the resident was to maintain intact skin by the next review. Some of the approaches the staff would implement to accomplish this goal included if wound had drainage to report to the physician, administered treatments as ordered by the physician and document, use pillows, supportive, protective devices with positioning. The Braden scale dated 6/21/18 and 9/18/18 assessed the resident was "at risk" for the development of pressure ulcers. The clinical record revealed the following regarding alterations in skin integrity: -6/14/18 at 2:30 p.m. (Nurse's notes) First indication of an area on the right buttock as reported by a Certified Nursing Assistant (CNA)	F 686	e. The Director of Nursing will round on all pressure wounds weekly to ensure what is on the wound report is the same that is being visualized at the bedside f. A monitoring tool was developed to track any new skin issues discovered to ensure they had a treatment and were being tracked for progress until resolution g. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 686	Continued From page 144 "brief had an unknown substance in it that was not BM or urine. Upon inspection of skin, there was no obvious open areas, but when palpating across right buttock, large amount of serosanquinous purulent drainage noted from a pin-point open area to the skin. Opening measured 0.1 x (by) 0.1 x 0.0. Drainage is foul smelling. Skin surrounding area is firm and warm to touch...long term care physician contacted x (times) 2 to report findings. Will notify oncoming shift. Dry dressing applied over site for protection..." -6/15/18 at 12:00 p.m. (Nurse's notes) "LTC physician contacted again regarding previously documented area on right buttock condition. Site remains unchanged..." -6/15/18 at 6:00 p.m. (Physician's order) "Culture right buttock on Monday 6/18/18. Keflex (oral antibiotic) 500 milligrams (mg) QID (4 x a day) x 7 days." -6/21/18 (Nurse Practitioner's progress notes) culture from abscess to right buttock revealed 2 different organisms at this time, proteus mirabilis and positive for MRSA (Methicillin Resistant Staphylococcus Aureus). To start gentamicin IM (intramuscular) x 7 days with pharmacy dose. Contact Isolation for MRSA. -6/22/18 at 4:00 p.m. (Medication Administration Record [MAR]) First does of gentamicin IM administered at 4:00 p.m. -Nurse's notes continue to document right buttock abscess on 6/23/18 at 9:15 p.m., 6/24/18 at 1:00 p.m. and 6/26/18 at 9:00 p.m. No measurements or descriptions documented for any of the above	F 686		

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F 686	Continued From page 145 dates. -Nurse's notes documentation on 6/27/18 at 8:00 p.m. and 6/29/18 at 2:42 a.m. the nurses notes document right buttock wound-no measurements or description. -Nurse's notes documentation dated 6/30/18 at 9:00 p.m. indicate right buttock wound-no measurements and no description. -Nurse's notes dated 7/1/18 at 2:17 a.m. and 10:00 a.m. changed to indicate a left buttock wound-no measurements and no description. -Nurses notes dated 7/2/18 at 1:00 p.m. documented the following: "...mild edema to skin surrounding the right hip abscess, but non-pitting. Area looks puffy. Right gluteal appears symmetrical to the left gluteal..." This documentation indicated skin integrity issues to both right and left gluteal areas, but further description, measurements or follow-up for treatment orders." No treatment orders for wound care. The next skin assessment was on 7/6/18 that notated-"skin intact." -Nurse's notes dated 7/2/18 at 3:00 a.m. and 9:00 p.m. indicated right buttock wound and that resident was still on contact precautions for MRSA. -Nurse's notes dated 7/5/18 at 9:00 p.m. indicated contact precautions for MRSA were discontinued. -The skin assessment flow sheets indicated the residents skin was intact until 6/15/18 and an existing area on 6/29/18. The skin assessment	F 686		

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F 686	Continued From page 146 sheets do do document any further or existing areas until 9/28/18. The Licensed Practical Nurse (LPN) #7 was interviewed on 4/2/19 and stated that he entered all of these entries with the exception of 3/2/18 and 3/9/18. He stated skin assessments were completed on the 3/11 shift and when entering information on the Skin Inspection Report it reflected the skin status with a notation of either skin intact (nothing anywhere) or Skin Not Intact-existing or new. He stated he could not recall the resident well, but knew he had some areas on his sacral and buttocks with an infection that he gave antibiotics for along with transmission precautions. -Nurse's notes dated 9/24/18 at 9:00 p.m. indicated the following: "Resident has skin breakdown to right buttock. He has several open areas, appears to be from moisture. Physician orders obtained to clean with dermal wound cleanser, *hydrogel applied and covered with dry dressing daily. MD made aware..." No measurements or descriptions documented regarding the several open areas. *Hydrogel is made up of about 90 percent water that is suspended in a gel base, and assists in providing the appropriate amount of moisture to assist the wound with healing. This can help the tissues debride, granulate and eventually heal fully (https://advancedtissue.com/2014/03/hydrogel-dressing-basics/). -Nurse's notes dated 9/25/18 at 2:50 p.m. indicated physician's orders for folic acid daily, vitamin C 500 mg. daily, zinc 220 mg daily and protein 30 ml twice a day. Hydrogel with dry dressing continued. -Nurse's notes dated 10/2/18 indicated	F 686		

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F 686	Continued From page 147 "...dressing intact to buttocks..." -Nurse's notes dated 10/3/18 indicated Resident #369 was transferred to the local hospital via 911 for vomiting episodes. From the review of the clinical record, the only physician orders for the right buttock dressing was on 9/24/18. There were no treatment orders presented to this surveyor for wound care/dressings the right buttock when first identified on 6/14/18. The nurses documented dry dressings applied over site for protection. The Director of Nursing (DON) was interviewed on 4/3/19 at 12:30 p.m. She stated what ever was in the record was all she could locate about Resident #369's skin integrity issues. She stated she was not sure if the abscess had ever healed or that there were new areas that developed. She stated they had standards of care meetings and daily meeting to discuss all resident care areas to include any wounds pressure and non-pressure related. She stated the only information about the resident's wounds were in the nurse's notes, no wound tracking forms were initiated which should have been for pressure and/ or non-pressure to clearly tract all wounds. The nurse's notes dated 10/3/18 at 7:30 p.m., indicated the paramedics arrived to transfer Resident #369 via 911 to the local hospital ER for evaluation due to vomiting. The hospital ER notes indicated Resident #369 arrived to the ER on 10/3/18 at 8:13 p.m. Review of the hospital's ER records revealed *unstageable sacral decubitus (same as pressure ulcers), 9.5 centimeters (cm) x 8.5 cm x 0.0	F 686		

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F 686	Continued From page 148 yellow slough wound bed. Other open areas were described as a bleeding area on posterior scrotum and a second open red area also on the scrotum. *Unstageable*Category/ Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). On 4/3/19 at 1:30 p.m., an interview was conducted with the MDS Coordinator. She stated from review of the clinical record, she could only find the 9/24/18 order that addressed any wound care to the right buttock. She also stated from her review of the documentation, she did not believe the right buttock had healed and it worsened in addition to a left buttock wound to incorporate the sacrum. She stated the staff should have initiated a Wound Assessment Report that would have identified the type of wound, tracked the wound, weekly assessment findings, cause, drainage, pain, measurements, any cultures, symptoms of infection, pulses if applicable, nutritional review, weight, physician contacts, responsible party contacted and the date when the wound resolved. She stated from	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 149 the nurses notes documentation she coded the resident with a skin lesion, not pressure. She said she does not do an "eyes on" assessment and depends on the nurses to document what they see during their assessments of the residents. She stated this type of document was started in the facility in 2012 and she did not know why Resident #369 did not have one. She stated the resident was on the standard mattress issued to all facility residents which was a pressure injury prevention mattress. She stated if the resident had multiple *Stage II pressure areas or greater, he should have been placed on a low air loss alternating pressure mattress. *Category/Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. Bruising indicates deep tissue injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/).. On 4/4/19 at 3:30 p.m., the Regional Quality Specialist (RQS) stated that upon her review of the clinical record, she thought the right buttock abscess had revolved and a new area started on 9/24/18 because the weekly Skin Inspection Report indicated the skin was intact from 7/6/18 through 9/21/18 and the isolation precautions were discontinued on 7/2/18. She stated it was not until 9/28/18 that there was documentation on	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 686	Continued From page 150	F 686		

this report to indicate skin not intact-"existing", but could not explain why LPN #7 did not document "new" for a newly identified area instead of "existing" which LPN #7 explained was how he documented areas on the Skin Inspection Report for areas already present. She stated it was her impression the areas on the Resident #369's sacral and or buttocks were from moisture and not pressure related. However, the RQC stated it was not plausible that a resident could leave the nursing facility on 10/3/18 at 7:30 p.m. without an unstageable sacral pressure ulcer and be assessed for one upon arrival in the ER on 10/3/18 at 8:13 p.m. She said the wounds may have merged into one that encompassed both the sacral and buttocks based on the assessed size presented in the ER. She stated all wounds were to be tracked via the Wound Assessment Report which would have clearly shown when a wound either resolved or worsened, as well as treatments and physician orders.

On 4/4/19 at 6:05 p.m., during a debriefing with the Administrator, DON and RQC, they stated they should recognize and discuss any and all changes with the residents durung the standards of care meeting. The DON stated she expected that the nursing staff conduct accurate assessments and treatment for residents with skin integrity issues that would include prevention and proper treatment of pressure ulcers.

On 4/4/19 at 6:30 p.m. during further interview with the Administrator and the RQC, the RQC restated the nursing staff should have identified a pressure ulcer at an earlier stage and not first identified as unstageable. The RQC stated she clearly understood there were problems with inaccurate assessments or lack of them for

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 686	Continued From page 151 Resident #369's skin, along with proper treatments. She stated, "I am going to do a sweep of the building to make sure accurate assessments are being done and bring this issue around 360 degrees." A telephone interview was conducted with the Resident Representative who was also the complainant on 4/4/19 at 1:10 p.m. She stated, on 10/2/18, the day before the resident was transferred to the hospital, she called a nurse down to change the resident because he had soiled himself. She stated that was the first time she saw the condition of the resident's "bottom" when the aide turned the resident on his side. She said, "I was not told about the extent of his wound. It was a large discolored, eaten away area. That is the only way I know how to describe it. I thought it was a little spot, that is what they would tell me."	F 686		
F 697 SS=D	Complaint Deficiency. 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, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to implement a complete pain program for two of 51 residents in the survey	F 697	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident # 370, and #373 are no longer in the facility **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who experience pain have the potential to be affected by the deficient practice.	

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 697	Continued From page 152 sample, Resident #373 and #370. 1. For Resident #373, facility staff failed to conduct a complete pain assessment and failed to evaluate effectiveness of pain medication. Facility staff also failed to clarify two different orders for pain medication. 2. The facility staff failed to provide pain management according to physician orders for Resident #370. The findings include: Resident #373 was admitted to the facility on 9/21/17 and readmitted on 2/2/19 with diagnoses that included but were not limited to pneumonia, hemiplegia (left sided paralysis) post stroke, and right clavicle fracture. Resident #373's most recent comprehensive MDS (minimum data set assessment) was a reentry assessment with an ARD (assessment reference date) of 2/12/19. Resident #373 was coded as being severely impaired in the ability to make daily decisions scoring two out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #373 passed away on 3/22/19 and is no longer a resident of the facility. On 3/20/19 a complaint was submitted to the OLC (Office of Licensure and Certification) regarding Resident #373 right clavicle fracture. Review of Resident #373's nursing notes revealed that Resident #373 had been transferred to the hospital due to critical laboratory tests on 1/26/19. The following note was written: "1/26/19 Critical Labs results called to (Name of physician). Order received to send resident out	F 697	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. A pain assessment was completed on all residents on 4/10/19 to identify any residents who were experiencing pain and the treatment provided. No pain was identified. b. The Director of Nursing and Assistant Director of Nursing were in-serviced on 4/16/19 over Pain assessments and documentation of the effectiveness of the treatment provided. c. All licensed nurses and certified nursing assistants were in-serviced over Pain Management Clinical Protocol Policy and Procedure by the Director of Nursing or Assistant Director of Nursing completed on 5/3/19. Emphasis was placed on clarification of orders, identifying pain, notification, treatment, and documentation of effectiveness of the treatment provided. d. A monitoring tool was developed to audit residents who are receiving as needed pain management and the effectiveness of the treatment provided if applicable. e. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 697	Continued From page 153 for blood transfusion." Review of Resident #373's emergency room report documented the following: Chief Complaint: low hgb (hemoglobin) (1). Patient is a 80 year old male with hx (history) of CVA (cerebrovascular accident) with L(left) hemiplegia and dysphagia (difficulty swallowing) (wheelchair bound. s/p (status post) PEG (peg tube), seizures...who presents from SNF (skilled nursing facility) for low hgb, was 5.7 yesterday. Advised to go to ER (emergency room)...C/O (complaints) R (right) shoulder/back pain. Fell out of wheelchair 2 weeks ago. Having pain since. Able to move arm ok." Further review of the hospital records revealed that an x-ray was conducted on 1/27/19 showing a right clavicle fracture. Resident #373's significant change MDS with an ARD of 2/12/19 documented Resident #373 as having a fracture. Review of Resident #373's nursing notes revealed that Resident #373 had a fall on 1/11/19. No injuries were documented. There was no additional evidence to show that Resident #373 had any signs or symptoms of further injury before his transfer to the hospital. Review of Resident #373's January 2019 POS (physician order summary) revealed the following orders: "Tylenol (2) 325 mg (milligrams) 2 Tabs (650 mg) via peg tube every 6 hours as needed for pain. Oxycodone-Acetaminophen (Percocet) (3) 5-325	F 697	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 697	Continued From page 154 mg tablet 1 tab via peg tube every 6 hours as needed for pain." Review of Resident #373's January 2019 MAR (medication administration record) revealed that Resident #373 received Tylenol 325 mg on the following date: "1/14/19." A pain assessment was not documented for this administration. A nursing note for the administration of Tylenol was not documented. Further review of Resident #373's January 2019 MAR revealed that he received Percocet 5/325 mg on 1/20/19 and 1/22/19. A pain assessment could not be found for 1/22/19. The following was documented for 1/20/19: "Percocet 5/325 mg. Reason: C/O Pain. Results: Effective at 3 AM." Location of pain and pain intensity was not documented on the MAR. Nursing notes could not be found for the administration of Percocet on 1/20/19 and 1/22/19. Review of Resident #373's comprehensive care plan updated 2/14/19, documented the following: "(Name of Resident #373) has a potential for alteration in comfort; Pain. Meds (medications) will be effective in maintaining adequate comfort level in this review period. Approaches: Encourage resident to report any pain noting location, duration, intensity (sic) and severity, Observe for effectiveness of pain meds for control of pain..." Further review of Resident #373's clinical record failed to evidence parameters on when to administer which pain medication. On 4/3/19 at 6:45 p.m., an interview was conducted with LPN (licensed practical nurse) #7,	F 697		

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F 697	Continued From page 155 a nurse who worked with Resident #373 full time. When asked the process if a resident complains of pain, LPN #7 stated that he would ask the resident to rate their pain on a scale from 1-10. (10 being the worst possible pain). LPN #7 stated that if the resident's pain is five or lower (mild) pain, he would administer Tylenol if there was an order. LPN #7 stated that he would administer stronger pain medication for pain at a six or seven, if there was an order. When asked if the pain intensity was documented anywhere in the clinical record, LPN #7 stated that it should be documented on the back of the MAR (medication administration record) or in a nursing note. When asked what else was assessed and documented for the pain assessment, LPN #7 stated that he would ask the location of pain. When asked what happened after pain medication was administered, LPN #7 stated he would reassess pain (30 minutes after pain medication was administered) and document the results on the back of the MAR or in a nursing note. When asked if nurses can determine which pain medication to give when, LPN #7 stated that they could. LPN #7 confirmed that the pain assessments for the above days were missing and/or incomplete. LPN #7 stated that Resident #373 never had any swelling, bruising or increased pain that would indicate a fracture prior to going to the hospital on 1/26/19. On 4/4/19 at 8:31 a.m., an interview was conducted with LPN #3, the 7-3 nurse most familiar with Resident #373. When asked the process if a resident complains of pain, LPN #3 stated that she would have the resident rate their pain on a pain scale from 1-10 (10 being the worst possible pain). LPN #3 stated that she would first attempt non-pharmacological	F 697		

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 697	Continued From page 156	F 697		

interventions for pain relief before giving medications. LPN #3 stated that she would then administer Tylenol for pain below a five or six and something stronger for pain at a seven or eight. When asked if it was up to nursing judgement to decide which pain medication to give when, LPN #3 stated that it was. When asked if all nurses would know to give Tylenol for mild pain at a five or six and something stronger for a pain of greater than six, LPN #3 stated that they should. When asked if was possible for a nurse to give strong pain medication to a resident who has a low pain level, LPN #3 stated, "It could be possible. It wouldn't generally happen." When asked if the pain orders should be clarified, LPN #3 stated, "It can be." When asked what was included in the pain assessment, LPN #3 stated that pain location and intensity was included in the pain assessment and that this information should be documented on the back of the MAR or in a nursing note. LPN #3 stated that she would also document any non-verbal signs/symptoms of pain such as facial grimacing, favoring one side etc. LPN #3 stated that if pain medication is administered, she would then document a follow up pain assessment evaluating the effectiveness of the medication.

On 4/5/19 at 9:30 a.m., ASM (administrative staff member) #1, the CEO (Chief Executive Officer) and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

(1) Hemoglobin (Hb) is the protein contained in red blood cells that is responsible for delivery of oxygen to the tissues. To ensure adequate tissue oxygenation, a sufficient hemoglobin level must be maintained. This information was obtained from The National Institutes of Health.

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F 697	Continued From page 157 https://www.ncbi.nlm.nih.gov/books/NBK259/. (2) Tylenol Tablet 325 mg (Acetaminophen)-Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details. (3) Percocet-Narcotic pain reliever used to treat moderate to severe pain. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3af57f54-117e-43fc-b0ae-21ef772d854e. Complaint Deficiency. 2. The facility staff failed to provide pain management according to physician orders for Resident #370. Resident #370 was originally admitted to the facility on 05/01/12. Diagnosis for Resident #370 included but not limited to *Urinary Retention, *Benign prostatic hyperplasia (BPH) and *Anxiety. Resident #370's MDS with an Assessment Reference Date (ARD) of 07/17/18 coded the resident's Brief Interview for Mental Status (BIMS) score 06 of a possible 15 which indicated severe cognitive impairment. In addition, the MDS coded Resident #370 requiring extensive of two with toilet use, transfer and bed mobility, extensive assistance of one with dressing, hygiene and bathing for Activities of Daily Living care. Resident #370 was coded occasionally incontinent of bowel and with indwelling *Foley catheter. Under section, J (Health Condition) was coded zero for the presence of pain.	F 697		

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 697	Continued From page 158 Resident #370 Comprehensive Person-centered care plan with a revision date 07/19/18 documented resident with a potential for alteration in comfort/pain. The goal: medications/treatment will be effective in maintaining adequate comfort level in this review period (10/19/18). Some of the intervention/approaches to manage goal included: Medications as ordered, observe for effectiveness of pain medications for control of pain and observe for non-verbal signs of pain (i.e., guarding moaning, restlessness, grimacing, diaphoresis, etc.). Review of Resident Physician Order Sheet (POS) for September 2018 included the following orders but not limited to: -Morphine Sulfate 0.25 ml (milliliter) by mouth for moderate pain every 3 hours as needed. -Morphine Sulfate 0.5 ml by mouth for severe pain every 3 hours as needed. According to the clinical note dated 09/16/18 at approximately 11:30 p.m., included the following: "Client crying out "Help" resident pointing at his scrotal/penis area complaining of pain. Scrotum is swollen with redness throughout and painful to touch. Resident with Foley catheter with red tinged streaks are in tubing with blood in the bottom of the drainage bag. Drainage bag has approximately 700 cc of dark colored urine." On the same day at approximately 11:45 p.m., according the clinical notes, Ativan 0.25 mg SL and Morphine 0.25 ml given for pain. Abdomen soft with audible bowel sounds. Milk of Magnesia was also given for constipation.	F 697		

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F 697	Continued From page 159 On 09/17/18 at approximately 12:00 a.m., according to Resident # 370's clinical note, resident's Foley catheter was removed due to excruciating pain exhibited via resident. Attempted x 3 to reinsert Foley without success. Resident is calmer after the catheter was removed. On the same day at 12:10 a.m., Hospice was notified of the residents change in condition; hospice said they were on their way. On 09/17/18 at 1:15 a.m., according to Resident #370's clinical note: Hospice arrived; assessment completed with the following: passing small amounts of urine, will leave Foley out. Send resident to Emergency Department (ED) for replacement of Foley. On the same day at approximately 2:45 a.m., Paramedics arrived to take resident to the hospital for further treatment but he refused to go...unable to persuade client to seek for further treatment. At 3:00 a.m., resident was medicated with Morphine 0.5 ml morphine. At 6:00 a.m., according to Resident #370's clinical note, resident had not voided-resident rates pain as 10 on a scale of 0 to 10, however there was no documentation that the resident was offered pain medication. According to the clinical record on 09/17/18 at approximately 7:30 a.m., resident with pain, pointing to his lower abdomen, abdomen is distended with no output since Foley removal; prn pain medication administered (Morphine 0.25 ml). Hospice nurse at bedside. On the same day at approximately 10:00 a.m., Resident #370 was sent to the local hospital for evaluation and treatment. Resident #370 returned to the facility at 6:00 p.m., with Foley catheter in place. Review of the hospitals discharge summary dated	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 697	Continued From page 160 09/17/18 included the following information: Today's visit: Diagnosis-problem with Foley catheter and new hernia (left side without obstruction or gangrene). Medication received during the hospital included: Ativan injection 1 mg administered at 12:03 p.m. No other medications administered during the hospital visit. A phone interview was conducted with LPN #2 on 04/04/19 12:05 p.m., who was Resident #370 nurse on 09/16/18 through 09/17/18 starting on the night shift (11p-7a.) The surveyor asked, "If you have an order to administer Morphine 0.25 ml for moderate pain and a order to administer Morphine 0.5 ml for severe pain; using the number scale, how much would you administer for moderate pain and how much would you administer for severe pain?" She replied, "I would give Morphine 0.25 ml for moderate pain on a numeral scale 1-6 and Morphine 0.5 ml for severe pain on a numeral scale 7 or above." The surveyor asked, "If you have a prn order for Morphine to be administered every 3 hours as need and the resident received their last dose at 3:00 a.m., when can the next dose of Morphine be administered?" The nurse said the next dose of Morphine could be administered at 6:00 a.m. The surveyor reviewed the nurse's note written by LPN #2 on 09/17/18 at 3:00 a.m. and at 6:00 a.m. The notes read: At 3:00 a.m., resident was medicated with Morphine 0.5 ml and at 6:00 a.m., resident rates pain as 10 on a scale of 0 to 10. The surveyor asked, "Based on the resident's pain at 6:00 a.m., should pain medication have been offered and/or administered" she replied, "Yes, Resident #370 should have received Morphine for severe pain." The LPN said Resident #370 had refused care throughout the 11-7 shift. She said the Morphine 0.5 ml was	F 697		

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 161 offered but the resident refused. The surveyor asked, "What is the process when a resident refuses medication that has been offered" she replied, "It should have been documented and by you asking that question, I am assuming it was never document, right." The surveyor replied, "I do not see any documentation that Resident #370 was offered Morphine 0.5 mg for sever pain or that he refused the pain medication (Morphine.) An interview was conducted with the Director of Nursing (DON) on 04/04/19 at approximately 4:02 p.m. The surveyor reviewed Resident #370's prn Morphine order with the DON. The surveyor also reviewed the clinical note written on 09/17/18 at 3:00 a.m. and 6:00 a.m. The surveyor asked, "If Resident #370 received Morphine 0.5 ml at 3:00 a.m., for pain and at 6:00 a.m.., the resident complained of pain 10/10, what is your expectations for your nurses if the resident has a prn Morphine order to administer every 3 hours as needed moderate pain (0.25 ml) and severe pain (0.5 ml)?" The DON said to give the Morphine according the order. She said if the pain level is at a 10/10 then the pain is unbearable the situation speaks for its self, the nurse should have administered the Morphine for severe pain. On 04/04/19 at approximately 4:50 p.m., an interview was conducted with the DON. The surveyor asked, "What is your expectations for your nurses if a resident refuse their pain medication that is being offered by your staff" she replied, "The nurses are expected to offer at least 3 times and document the refusal in the resident's medical record." The facility administration was informed of the	F 697		

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F 697	Continued From page 162 finding during a briefing on 04/04/19 at approximately 6:05 p.m. The facility did not present any further information about the finding. The facility's policy titled Pain - Clinical Protocol (Revised March 2018) Definitions: 1). Urinary retention is the incomplete emptying of the bladder (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition). 2). BPH also called prostate gland enlargement - is a common condition, as men get older. An enlarged prostate gland can cause uncomfortable urinary symptoms, such as blocking the flow of urine out of the bladder. It can also cause bladder, urinary tract or kidney problems (https://www.mayoclinic.org/diseases.../benign-prostatic-hyperplasia). 3). Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm). 4). Foley catheter is a tube placed in the body to drain and collect urine from the bladder (<https://medlineplus.gov/druginfo/meds/a682514.html). 5). Morphine Sulfate Morphine is used to relieve moderate to severe pain (https://medlineplus.gov/druginfo/meds/a682514.html). 6). Ativan is used to relieve anxiety	F 697		

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F 697	Continued From page 163 (<https://medlineplus.gov/druginfo/meds/a682514.html>). Compliant deficiency.	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #65 was assessed by the Psych Nurse Practitioner on April 12, 2019 with documentation of the outcome of that assessment. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who require gradual dose reductions have the potential to be affected by the deficient practice.	

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F 758	Continued From page 164 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure GDR (gradual dose reductions) were attempted for one of 51 residents in the survey sample, Resident #65. The facility staff failed to ensure that a gradual dose reduction for the medication Seroquel was attempted for Resident #65. The findings Included: Resident #65 was a 77 year old admitted to the facility on 3/16/18 with diagnoses to include but not limited to Dementia and Affective Mood Disorder. The most recent Minimum Data Set (MDS) Assessment for Resident #65 is a Quarterly with an Assessment Reference Date (ARD) of 2/19/19. Resident #65's Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15	F 758	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. The Director of Nursing and Assistant Director of Nursing were in-serviced by the Regional Quality Specialist on 4/5/19 over the Medication Therapy Policy and Procedure emphasizing all residents receiving an anti-psychotic will be assessed for a gradual dose reduction every 12 months with documentation of the outcome. b. An audit of all residents receiving an anti-psychotic was completed on April 12, 2019 to ensure that an assessment had been completed for a gradual dose reduction with documentation of the outcome. c. A monitoring tool was developed to track residents receiving an anti-psychotic and that gradual dose reductions were assessed and documentation of the outcome was done at least every 12 months. d. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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F 758	Continued From page 165 indicating the resident was cognitively intact and capable of daily decision making. Under Section E-Behaviors the resident was coded as having "Behavior Not exhibited for the ARD period. Under Section N-Medications Resident #65 was coded as receiving an antipsychotic medication for 7 days during the ARD period. Under GDR (Gradual Dose reduction) attempted Resident #65 was coded as: No. Resident #65's Comprehensive Care Plan dated 2/21/19 was reviewed and is documented in part, as follows: Problem: Name (resident #65) has a potential for side effects from use of psychotropic medications-on antipsychotic and antidepressant. Approaches: *Continued evaluation by Psych (psychiatric) services of effectiveness and benefits of medication. Notify physician of recommendations. *Med. (medication) review for gradual dose reduction. Resident #65's Discharge Summary dated 3/16/2018 was reviewed and is documented in part, as follows: Current Discharge Medication List: Quetiapine SR(sustained release) (Seroquel XL) 200 mg (milligrams) take one tablet by mouth every night at bedtime. Resident #65's current Physician Orders signed 4/4/19 were reviewed and are documented in part, as follows:	F 758	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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F 758	Continued From page 166 Original Order Date: 3/16/18: Quetiapine ER 200 mg tablet, 1 tablet by mouth every night at bedtime DX: Mood Disorder. Resident #65's Physician Progress Notes were reviewed and are documented in part, as follows: DOS(Date of Service): 7/16/2018 Plan: Behavior disturbance patient continue on current medication as well as being closely followed by psych as needed along with may benefit from (Name) psychological services. DOS: 9/20/2018 Plan: Behavior disturbance patient continue on current medication as well as being closely followed by psych as needed along with (Name) psychological services. DOS: 11/12/2018 Plan: Mood disorder he will continue to benefit from being followed by in house psych or (Name) Psychological services. Resident #65's Monthly Pharmacy Medication Review was reviewed and is documented in part, as follows: 3/27/18 Psychoactive Medications: Seroquel XR On 4/3/19 02:30 PM the Director of Nursing was asked for the Pharmacy Reports of the gradual dose reductions for Resident #65. The Director of Nursing stated, "The pharmacist doesn't do our gradual dose reductions Name (Psychiatric Nurse Practitioner for Company Name) does all our psych medication reviews and gradual dose reductions. I will get them for you."	F 758		

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F 758	Continued From page 167 On 4/4/19 at 04:00 PM the Assistant Director of Nursing provided the following signed statement regarding Resident #65 to this surveyor which was reviewed and documented in part, as follows: 1. Patient was readmitted on 3/16/18. 2. On admission orders for the readmission, an order was written for Seroquel XR 200mg every night; dx (diagnosis): mood disorder. 3. Upon researching the chart there were no GDR (Gradual Dose Reductions) found from 3/16/18 to present day. 4. There was no progress note found from Name (Psychiatric Nurse Practitioner for Deer Oaks) she is the person that we use for GDR. 5. Currently the patient is still on seroquel 200 mg every night. The facility policy titled "Behavioral Assessment, Intervention and Monitoring" revised 12/2016 was reviewed and is documented in part, as follows: Policy Statement 3. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. Management: 10. When medications are prescribed for behavioral symptoms, documentation will include: a. Rationale for use; b. Potential underlying causes of the behavior; c. Other approaches and interventions tried prior to the use of antipsychotic medications; d. Potential risks and benefits of medications as discussed with the resident an/or family; e. Specific target behaviors and expected outcomes;	F 758		

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F 758	Continued From page 168 f. Dosage; g. Duration; h. Monitoring for efficacy and adverse consequences;and i. Plans (if applicable) for gradual dose reduction. Monitoring: 5. If antipsychotic medications are used to treat behavioral symptoms, the IDT (inter-Disciplinary Team) will monitor their indication and implement a gradual dose reduction, or document why this cannot or should not be done. On 4/4/19 at approximately 6:05 PM a pre-exit debriefing was held with the Administrator, the Director of Nursing, and the Regional Quality Specialist where the above information was shared. Prior to exit no further information was shared.	F 758		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on information obtained during a complaint investigation, clinical record review and staff interviews the facility staff failed to provide laboratory services for one of 51 residents (Resident #372), in the survey sample.	F 770	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. The resident identified was discharged to the hospital. b. Residents who have labs ordered will be drawn as scheduled and followed up with the ordering physician. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents who receive orders for lab services have the potential to be affected by the deficient practice.	

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F 770	Continued From page 169 The facility staff failed to obtain Resident #372's labs (a complete blood count and a basic metabolic panel) ordered 9/19/18. The findings included: Resident #372 was originally admitted to the facility 7/23/18, and was discharged from the nursing facility to an acute care hospital 9/21/18. Resident #372's diagnoses included; renal insufficiency, heart failure and high blood pressure. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/31/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #372's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with eating, extensive assistance of one person with locomotion, extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene, total care of one person with bathing. Review of the clinical record revealed an order dated 9/19/18, for a complete blood count and a basic metabolic panel, the laboratory results were not located. An interview was conducted with Licensed Practical Nurse (LPN) #8 on 4/4/19 at approximately 12:30 p.m. LPN #8 stated when the physician's order is received, a laboratory requisition is completed and put in the lab book	F 770	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. An audit of all current residents was completed on April 26, 2019 from January 2019 until present to ensure all labs ordered were drawn as scheduled and followed up by the ordering physician. b. All nursing staff was in serviced by the Director of Nursing or Assistant Director of Nursing over the Lab Diagnostic Test Results Policy and Procedure emphasizing that labs are to be drawn as scheduled and follow up with the ordering physician will occur completed on May 3, 2019 c. A monitoring tool was developed to track all labs ordered to ensure they were drawn as scheduled and followed up on by the ordering physician. d. This monitoring tool will be utilized weekly x 1 month, then weekly x 2 weeks, then randomly x 3 months.	

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F 770	Continued From page 170 for the laboratory tech, the laboratory tech obtains the specimen and takes it to the lab. The lab sends the laboratory results to the facility and the licensed nurse notifies the physician and puts the laboratory results on the clinical record. An interview was conducted with the Director of Nursing 4/4/19 at approximately 2:40 p.m., the Director of Nursing stated the 9/19/18 lab was likely not obtained, since there was no record of collection or results. On 4/4/19, at approximately 2:40 p.m., the above findings were shared with the Administrator, and Director of Nursing. The Director of Nursing stated the lab should have been obtained or the physician should have been notified of the inability to obtain the lab.	F 770	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	
F 812 SS=F	Complaint Deficiency. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Food was not prepared, distributed and severed under sanitary conditions. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected.	

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F 812	Continued From page 171 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's policy, the facility staff failed to ensure the food was prepared, distributed and served under sanitary conditions. The finding included; On 04/01/19 at approximately 4:50 PM an initial tour was conducted with Dietary staff (Other Staff #9). Surveyor placed on hair net and asked Dietary staff to direct her to where she should wash her hands. There was a moderate amount of soap inside of the dispenser but it wouldn't come out. The dietary staff was asked how long have they been out of soap and is this where the Dietary staff usually wash their hands? Other staff #9, said yes! He was then asked by the surveyor how long has the soap dispenser been out of order? He stated "since yesterday". He said that it just need batteries. He was then asked by the surveyor to show her where else could she wash her hands. The Other staff #9, then lead the surveyor to an area outside of the kitchen called the "prep" area, to a large sink to wash her hands. The following was observed while on the initial tour of the kitchen: 1. Soap dispenser not working. 2. Staff washing hands without applying soap. 3. "Dialysis" lunch bag with food not labeled with a date located in the reach-in refrigerator.	F 812	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. Kitchen staff were unable to wash hands due to soap dispenser not working. Batteries were replaced on 4/3/19. FDS gave the surveyor the Personal Hygiene and Handwashing In-service on 4/4/19 showing 8 employee's participation. b. Dialysis lunch bag with food not labeled with date. Corrected immediately. c. Staff drinks were observed in reach-in refrigerator. Items removed. d. Container of cottage cheese, bag of shredded coconuts and jello were items that were expired. Removed during tour. e. Cartons of milk and juices were observed sitting in standing water in a pan in the walk in cooler. Pan of juices and milk were removed during survey. Food services will discontinue placing pan in the cooler 4/4/19. f. During tray service while checking temperatures the FSD would wipe off the thermometer off with an alcohol pad and/or use a paper towel. The cook rinsed of the thermometer under running water between food and did not always clean it off. Was observed placing the thermometer on the counter and re-using it without cleaning it. The FSD was educated on proper cleaning of thermometer on 4/8/19 and has educated the cooks on 4/9/19	

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F 812	Continued From page 172 4. 1 Opened bottle of Dr. Pepper located on the top shelf in the reach-in refrigerator. 5. 1 unopened can of Red Bull on the top shelf of the reach - in reach refrigerator. 6. 1 80oz. container of cottage cheese with expiration date of 03/25/19 located in the reach-in refrigerator. 7. 2 unopened bags of shredded coconuts and 1 half full bag of shredded coconut with expiration dates of 10/27/18 located in walk-in cooler on left side. 8. An aluminum pan of "red" jello 1/2 full, dated 03/21/19 was located in the walk-in cooler on the left side. The FSD (Food Service Director) states she keep jello for 7 days then discards. 9. Cartons of milk and juices sitting in standing water in an aluminum pan in the walk in cooler to right. On 04/02/19 at approximately 10:00 AM, observation of kitchen was made. Soap dispenser still not working. Staff observed turning on water, washing hands without soap. Some dietary staff were observed not washing their hands. Spoke to several staff members they state that they wash their hands when they enter the kitchen.. Other staff #11, stated she will open up soap dispenser and squeeze soap into her hands. She was asked how long has the soap dispenser not worked. She stated it's been a week. On 4/02/19 at approximately 11:15 AM, the FSD and kitchen staff were using the thermometer to check food temperatures. The FSD would sometimes use the alcohol wipe to wipe off the thermometer and/or use a paper towel. The cook ran the thermometer under running water or between food he wouldn't always clean it off. He	F 812	g. Tracking sheet is being used as of 4/8/19 to record the refrigerator and dry foods labels and dates. h. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur**. a. The Food Service Director will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	

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	495150	A. BUILDING _____ B. WING _____	C 04/05/2019

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F 812	Continued From page 173 was observed placing the thermometer on the counter and re-using it without cleaning it off first. 04/02/19 at 5:00 PM. it was observed a staff member thawing multiple cartons of orange drink mix in the sink using hot water. When she saw the surveyor she left her station and proceeded towards the sink saying "I thought I was running cold water" She immediately turned off the hot water. Dumped the hot water from the plastic container and began to run cold water on orange drinks. On 04/03/19 an interview and kitchen walk through was conducted with The Food Services Director concerning the above issues. She states that the soap dispenser needs batteries and that she will put batteries in dispenser sometime today. She also stated that she will do staff education and training on proper hand hygiene. On 04/04/19 it was observed that the non-working soap dispenser was replaced with a new soap dispenser and working. Surveyor was given the Personal Hygiene and Hand Washing Inservice/Training form from Food Service Director (Other Staff #5). The form listed the names of eight dietary staff employees. On 04/04/19 at approximately 5:30 PM the Administrator and Director of Nursing were informed of the above findings. No further information was provided by the facility staff.	F 812	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. During observation of the dumpster there was trash and crushed boxes in the area.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly.	F 814	**(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected.	

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F 814	Continued From page 174 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's policy, the facility staff failed to dispose of garbage and refuse properly. The finding included; On 04/02/19 at approximately 11:05 AM a tour of the outside dumpster area, which was located across the building entrance, was conducted with the Food Service Director (FSD). 3 dumpsters were observed and located on the ground behind the dumpsters was trash, crushed boxes, debris, gloves and 1 can of beer. The FSD started picking up the trash as we were leaving the area. The FSD said that the dietary staff should be keeping the dumpster area clean but maybe other staff were bringing their trash out too. On 04/04/19 at approximately 5:30 PM a brief interview was conducted with the Administrator and Director of Nursing they were informed of the above findings. No comments were made.	F 814	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. Food Service Manager was given the policy and procedure for disposing trash in the dumpster and re-educated by the CEO on 4/8/19. FSD in turn re-educated both dietary and housekeeping staff. b. Tracking sheet is being use to check dumpster area twice a day. c. Area will be cleaned when items are found in the dumpster area. d. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Food Service Director will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed	
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, a complaint review and staff interviews, the facility staff failed to utilize the operating budget effectively and efficiently in	F 835	**(5) Completion Date: 5/17/2019**	

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F 835	Continued From page 175 order to ensure service accounts were paid timely. The facility did not paid laboratory services and lawn services which ceased to provide services to the facility. The findings included: The facility staff failed to utilize the facility's operating budget effectively and efficiently. Facility staff failed to pay laboratory service vendor timely and the services were stopped. The facility staff failed to pay for lawn service vendor and the services were stopped. A review of the facility's Vendor activity payment voucher indicated the facility stopped paying the Lawn Service vendor in 2018. During an interview on 4/3/19 at 10:00 A.M. with the administrator he stated, the Lawn service was not paid by the cooperate office. The administrator stated, he submitted the billing and payment summaries to the cooperate office each month as the bills were due. Review of an invoice dated 6/30/18, revealed that the facility owed this vendor 10,875.00. During individual and group interviews it was stated, that the grass was not cut for weeks. Often times the grass grew up to two feet tall. During the interview with the administrator he was asked if the city had sent the facility a notice regarding the grass needing cutting and he stated, "Yes." A review of the facility's Vendor activity payment voucher indicated the facility's laboratory services vendor ceased to provide services because the facility had not paid the vendor. The lab vendor services were stopped September 2018. The facility entered a contract with another lab service in September (9/8/18). A review of the current	F 835	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Residents with acute labs were taken to the hospital. b. Maintenance Department mowed the grass. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents have the potential to be affected. **(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. A new lab company started on 9/8/18 b. Lawn service was put on payroll to be paid every 2 weeks. c. This will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed with the Regional Vice President and Regional Quality Specialist.	

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F 835	Continued From page 176 billing (APRIL 2019) cycle for the facility's lab services indicated: Lab services dated 04/03/2019: past due amount owed $31,793.46. During an interview on 4/3/19 at 10:15 A.M. with the administrator he stated, the cooperate office had not paid the lab vendor as of today (4/3/19) . When asked what additional services had been stopped or cut off notices sent to the facility for non-payment, the administrator stated, the Public Utility Services vendor and the Electric Power vendor had sent "CUT OFF NOTICES". A review of the current billing (APRIL 2019) cycle for the facility's water services indicated: Water services dated 03/22/2019: past due amount owed $1,120.26 . Current amount due is $1,135.76. A cut off notice was sent to the facility indicating that water services would be interrupted if payment was not received immediately. A "DO NOT MAIL PAYMENT NOTICE" was attached to the bill. A review of the current billing (APRIL 2019) cycle for the facility's sewage services indicated: Sewage services dated 03/22/2019: past due amount owed $2,585.32. A current amount due is $2,600.35. A Cut off notice was sent to the facility indicating the sewage services would be interrupted if payment was not received immediately. A "DO NOT MAIL PAYMENT NOTICE was attached to the bill. A Public Utilities and Public Works City Services Bill dated 3/29/19 indicated: UN PAID-January 2019 amount owed: $2,384.10 UN PAID-February 2019 amount owed: $1,827.61 UN PAID-March 2019 amount owed: $ 1,831.96 TOTAL amount due $ 6,943.67	F 835	**(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Administrator and Director of Nursing will present findings to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed. **(5) Completion Date: 5/17/19**	

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F 835	Continued From page 177 A SERVICE TERMINATION notice was attached to the bill. The bill due date is April 19, 2019. A Electric Service Bill dated March 18, 2019 indicated: "DISCONNECT NOTICE" Your past due balance of $14,203.08 must be received by 5:00 P.M. on March 29, 2019 to avoid disconnection. of services. Billing and Payment Summary - Due Date: April 09,2019 Total amount due $46,995.70. Past due amount by 03/29/19 - $14,203.08 Current amount due by 04/09/19 - $32,792.62 (the bill indicated: SEE DISCONNECT NOTICE ABOVE). During an interview with the administrator on 04/05/19 at 11:30 A.M. he was asked why the bills are not being paid timely. The administrator stated, "He sends the bills to the cooperate office timely and as they come into the facility. The cooperate office are not paying the bills." An Administrative Management (Governing Board) Policy indicated: The governing board shall be responsible for the management and operation of the facility. 3. The governing board is responsible for, but not limited to: a-Oversight of facility care and services in accordance with professional standards of practice and principles.	F 835		
F 924 SS=D	Complaint Deficiency Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3)	F 924	F-924 **(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. During environmental rounds it was observed that lower rails at room #103 and unit 2 and hand rail at room #105 were loose. Lower rails and hand rail were repaired on 4/5/19. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected.	

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F 924	Continued From page 178 §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to ensure hand rails and foot rails were firmly affixed. The findings included: During the Environmental Tour on 4/5/19 at 9:00 A.M. the lower foot rail at Unit II nursing station was observed to be loose. Nursing staff were observed resting there feet upon the rail. On Unit IV at room 103 the lower rail was observed loose. The hand rail at room 85 was observed to be loose. During an interview on 4/5/19 at 11:30 A.M. with the Administrator he stated Maintenance personnel would be informed and the rails would be tightened.	F 924	**(3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur.** a. Hand and lower rails will be added to maintenance's round sheet to check for loose rails. b. Observational daily rounds started on 4/8/19. c. Any loose railing will be repaired immediately. d. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Maintenance will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	
F 925 SS=F	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 observations, record review and staff interviews the facility staff failed to maintain an effective pest control program. The findings included: The facility staff failed to maintain an effective	F 925		

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F 925	Continued From page 179 pest control program. Live roaches were observed on 4/3/19 at 10:00 A.M. on the main business office corridor. During the Environmental tour on 4/5/19 at 9:00 A.M. dead roaches were observed in the Unit II shower room. A live roach was observed at Unit II supply room door. Unit II storage room (number two) was observed to have several dead roaches on the floor. Dead roaches were observed in the main activity room light fixtures. On Unit 3-A: live roaches were observed on the Day room floor. A live roach was observed in room 67. A dead roach was observed in the hallway at room 71. On Unit 5-A: Dead roaches were observed in the shower room. A review of the facility's pest log indicated the following: " Unit I- On 1/21/19 in the Activity office roaches were observed On 3/15/19 in room 55 a water bug was observed. On 3/19/19 in rooms 50 and 52 water bugs were observed. On 3/25/19 in Social Service office ants were observed. On 3/26/19 in room 117 roaches were observed. On 4/3/19 Men's bathroom water bug was observed. Unit 3-A On 3/20/19 entire unit were observed with roaches. On 4/1/19 hallway floors and rooms roaches observed. On 4/4/19 Room 71 roaches observed.	F 925	**(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Facility did not maintain an effective pest control plan. An audit of the facility was completed on 4/15/19 and any pests discovered were removed. **(2) How the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All resident have the potential to be affected. (3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur. a. On April 10, 2019 a revised pest contract for services was signed. This new contract increases services to treat units 1 and 3 every two weeks. Units 2 and 4 every two weeks in addition to the regular pest control program. b. Maintenance Director was re-educated on pest control policies and procedures on 4/5/19 by the CEO. c. Reporting of pests will be documented on the Pest Sighting Log. d. Maintenance Director will monitor sighting log to see that the extra treatments are effective. e. Maintenance Director will remind the nursing units prior to treatments. f. Pest vendor has provided treatment on 4/12/19 & 4/17/19.	

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F 925	Continued From page 180 Unit 4- On 12/10/18 room 94 Roaches were observed. On 12/19/18 Unit 4 nursing station tic/beg bugs were observed. On 1/9/19 room 94-B roaches were observed in the dresser drawer. On 1/15/19 room 94 roaches were observed in the closet and dresser drawer. On 2/20/29 rooms 116 and 118 ants were observed. Unit 5- On 8/9,10,11, and 12 staff sight roaches in the hallway, resident rooms nursing station, med room, activity rooms. Staff wrote, "Roaches are all over this unit." On 9/25/18 staff writes again, "Roaches are all over this unit." On 9/25/18 Roaches found in residents bed room 83 beds A and B. 12/24/18-Roaches-whole unit 5. On 2/19/19-staff wrote, "Roaches unit 5 all rooms." A review of the Pest Management Contract dated 2/10/15 indicated: "Mission-We shall first seek to understand the unique needs of each customer, formulate effective solutions, and implement the actions in a timely professional manner." During an interview with the Administrator on 4/5/19 at 2:15 P.M., he was asked if the pest company utilized by the facility was effective. The Administrator stated the facility "had been with the company for a number of years." The facility staff failed to maintain and effective pest control program.	F 925	g. 4/12/19 a staff member was assigned to complete a 100% room audit to check resident's dressers and night stands for open food items. Food items that were found were placed in zip-locked bags h. Performance Improvement Plan and monitoring tool (Pest Sighting Logs) will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/ or suggestions and follow-up as needed. **(4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** a. The Director of Maintenance will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed **(5) Completion Date: 5/17/19**	