STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT BOTETOURT COMMONS	290 COMMONS PARKWAY DALEVILLE, VA 24083

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/09/19 through 04/11/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Three complaint(s)were investigated during the survey.	E 000		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	E 036		5/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/10/2019

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E 036	Continued From page 1 preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on emergency preparedness review, facility document review, and staff interview the facility staff failed to complete testing of their emergency preparedness plan in regards to fire drills. The findings included: The facility failed to complete fire drills for the months of June and September 2018. During the emergency preparedness review, the facility was asked to provide evidence of training in regards to fire drills. The facility was unable to provide any evidence of fire drills that were completed in June and September 2018. The administrator was notified of the issues with the fire drill training on 04/11/19 at 8:50 a.m. The administrator verbalized to the surveyor that they had some staff changes in the maintenance department. The administrative team were notified of the above during a meeting with the survey team on 04/11/19 at 12:45 p.m. No further information regarding this issue was	E 036	E036: 1. Facility fire drills are up to date and compliant with E036 requirements for fire drills. 2. All residents have the potential to be at risk. 3. Facility Maintenance Director and Maintenance Assistant were inserviced by Executive Director regarding the requirements for Fire Drills. A monthly audit of fire drills to be completed by Executive Director to ensure that fire drills are completed once per shift each quarter. This audit will be completed for a period of eight (8) weeks. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary.	

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E 036	Continued From page 2 provided to the survey team prior to the exit conference.	E 036		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard/complaint survey was conducted 4/9/19 through 4/11/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 21 current Resident reviews and 3 closed record reviews.	F 000		
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	F 583		5/17/19

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F 583	Continued From page 3 than a postal service. §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, facility document review and staff interview, the facility staff failed to provide privacy and confidentiality of 1 of 24 residents in the survey sample (Resident #76). The findings included: The facility staff failed to provide privacy and confidentiality for Resident #76 during the medication observation made by the surveyor on 4/10/19. Resident #76 was admitted to the facility on 3/15/19 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary artery disease, high blood pressure, diabetes, seizure disorder, anxiety disorder, depression and manic depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #75 was also coded as requiring limited assistance of 1 staff member for dressing,	F 583	F583 1. LPN #1 has been educated on locking laptop screen when stepping away from medication cart in order to ensure privacy of patient medical information. 2. An audit of medication pass was completed by Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure licensed nursing staff locks laptop screens before leaving medication carts in order to ensure privacy of patient medical information. No other issues identified. 3. Licensed Nursing Staff to be inserviced by DON or designee regarding the protection of privacy of patient medical information during medication passes. A random audit of medication passes across all shifts to be completed by DON or designee to ensure laptops are locked by licensed nursing staff before stepping away from medication cart to ensure privacy of patient medical information. This audit is to be completed three times	

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F 583	Continued From page 4 personal hygiene and bathing. During the medication observation on 4/10/19 at 8:26 am, the surveyor observed LPN (licensed practical nurse) #1 went into room 110 to wash her hands. The laptop on top of the medication cart was left open and medical information could be readily visible to anyone in the hallway at that time. The nurse could not view the medication cart's laptop while she was in the bathroom. The surveyor asked LPN #1how she is to leave the computer screen when she walks away from the medication cart. LPN #1 stated, "I'm suppose to lock the screen." The surveyor notified LPN #1 that she did not lock her screen when she went into the bathroom in the resident's room at 8:26 am. The surveyor notified the administrative team at 1 pm of the above documented observation. At 3:55 pm, the surveyor requested and received the facility's policy titled "Confidentiality of Information and Personal Privacy" which read in part, " ...The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records ...Access to resident personal and medical records will be limited to authorized staff and business associates ..." No further information was provided to the surveyor prior to the exit conference on 4/11/19.	F 583	per week for a period of eight (8) weeks. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		5/17/19

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F 684	Continued From page 5 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 2. For Resident #41, the facility staff failed to ensure the Resident followed up with neurosurgery. The clinical record review revealed that Resident #41 had been admitted to the facility on 07/19/17. Diagnoses included but were not limited to, quadriplegia, muscle weakness, chronic pain due to trauma, central cord syndrome at C2, and spinal stenosis. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/10/19 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section G (functional status) had been coded (3/3) to indicate the Resident required extensive assistance of two people for bed mobility and transfers, locomotion on and off the unit and eating had been coded (4/2) to indicate the Resident was totally dependent on one staff to complete these tasks. The Residents comprehensive care plan included the following problem areas. History of refusing care, refusing medications, and verbally abusive behavior. Interventions included, but were not limited to, take medications as ordered, reinforce with Resident unacceptability of verbal abuse, do	F 684	a. Resident #41's appointments are current. b. Resident #91's physician was notified of the missed antibiotic. Resident did not experience a negative outcome. 2. a. An audit of all admissions within the last 30 days was completed by Executive Director and designees to ensure follow up appointments noted on discharge summaries were followed through. No other issues identified. b. A 100% audit of all residents with orders for IV antibiotics to ensure physician orders were followed. No other issues identified. 3. a. Licensed nursing staff and facility nursing clerk inserviced by DON and designee regarding scheduling patient appointments in accordance with physician orders. Facility Medical Records manager and designee to complete weekly audit of physician orders, discharge summaries, and patient consult sheets to ensure follow up appointments are scheduled. Facility to complete audit for a period of eight (8) weeks. b. Licensed nursing staff inserviced by DON and designee regarding	

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F 684	Continued From page 6 not argue with Resident, and monitor and document behaviors as they occur. The Residents clinical record included a Progress note dated 08/04/17 in regards to an office visit with the neurosurgery department at a local clinic. Page 4 of this document read in part, "...Patient should follow up in 6-8 weeks with me or another ACP for surgical followup..." The facility provided the surveyor with an encounter note dated 08/30/17 that read "Working Recall Report. Attempted to call patient to schedule a follow up appointment with _____, PA (physician assistant). Patient did not answer and a message was left on an unidentified voicemail. If patient calls back please inform of the above information and schedule appointment." During an interview with this Resident the Resident stated he was supposed to have followed up with the physician but he did know when or who to contact he named MRS (medical records staff) #1 as the person who was scheduling the appointments. During an interview with MRS #1 on 04/10/19 at 8:44 a.m., MRS #1 stated if the Resident went out and upon return to the facility did not let us know he had a follow up appointment we would not have known. MRS #1 stated no staff person would have went with this Resident if they were alert and orientated but they would have made the family aware. On 04/10/19 at 9:39 a.m., the surveyor interviewed LPN (licensed practical nurse) #3 regarding the Residents appointment and follow	F 684	administering medications in accordance to physician orders. Facility DON and designees to complete an audit of MAR three (3) times per week for a period of eight (8) weeks to ensure medications administered in accordance to physician orders. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary.	

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F 684	Continued From page 7	F 684		

up appointment. LPN #3 read the note she had transcribed and stated the Resident had a consult sheet when he returned to the facility or she would not have known what to document in the Residents clinical record (this progress note was given to the surveyor prior to exit).

The DON (director of nursing) was asked for a copy of this consult sheet. However, it also was not provided prior to the exit conference.

On 04/10/19, the facility scheduled the Resident a follow-up appointment with neurosurgery on April 24, 2019.

The administrative staff were notified of the issue regarding the Residents follow-up appointment with the neurosurgeon on 04/11/19 at 12:45 p.m.

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

THIS IS A COMPLAINT DEFICIENCY.
Based on staff interview, clinical record review and facility document review the facility staff failed to follow physician's orders and/or consult for 2 of 21 Residents, Resident #91 and Resident #41.

The findings are as followed::

For Resident #91 the facility staff failed to administer the intravenous (IV) antibiotic, Ceftriaxone, per the physician's orders.

Resident #91 was admitted to the facility on 12/03/18 and readmitted on 02/09/19. Diagnoses included but not limited to hypertension, benign prostatic hyperplasia, hyperlipidemia, depression,

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F 684	Continued From page 8	F 684		

insomnia, urinary tract infection and retention of urine.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/05/18 coded the Resident as 12 of 15 in section C, cognitive patterns. This is an admission MDS.

Resident #91's clinical record was reviewed on 04/10/19. It contained a signed physician's order summary, which read in part "Ceftriaxone 2 gm piggyback q (every) 12 hours." This order had a date of 02/09/19.

According to "Davis Drug Guide", ceftriaxone is an antibiotic used to treat bacterial infections. According to to "Tabor's Medical Dictionary", IV piggyback is the administration of a medication diluted in a small amount of IV solution.

Resident #91's eMAR (electronic medication administration record) contained an entry, which read in part "Ceftriaxone 2 gm piggyback q 12 hours. Order date: 2/9/19. Start date: 2/9/19...." This entry was coded "N" for 02/09/19 at 10 pm and 02/10/19 at 10 am. Administration record notes for these dates read in part, "2:24 PM, 2/10/19 (Scheduled: 10:00PM, 2/09/19; CEFTRIAXONE 2 GM PIGGYBACK) CEFTRIAXONE 2 GM PIGGYBACK q 12 hour scheduled for 02/09/2019 10:00 PM was not administered-Other.awaiting pharmacy..." and "2:24pm, 2/10/19 (Scheduled: 10:00AM, 2/10/19; CEFTRIAXONE 2 GM PIGGYBACK) CEFTRIAXONE 2 GM PIGGYBACK q 12 hours scheduled for 02/10/2019 10:00 AM was not administered-Other.awaiting form pharmacy...."

The surveyor requested and DON (director of

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F 684	Continued From page 9 nursing) provided a copy of a facility policy entitled "Medication Administration-General Guidelines", which read as follows: "Policy Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures A. Preparation 11) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit." The surveyor requested and the DON provided a copy of the contents of the facility emergency medication box. The medication ceftriaxone 2 gm vial is listed as available in the emergency box. The surveyor spoke with the DON on 04/10/19 at approximately 1350 regarding administering IV medications. The DON stated IV supplies were available in the medication room. The concern of not administering the Resident's medications per the physician's orders was discussed with the administrative staff during a meeting on 04/10/19 at approximately 1255. No further information was provided prior to exit.	F 684		
F 756	Drug Regimen Review, Report Irregular, Act On	F 756		5/17/19

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F 756 SS=D	Continued From page 10 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

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F 756	Continued From page 11 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documet review, the facility failed to follow up on pharmacy recommendations for 2 of 24 Residents, Residents #18 and #39. The findings included: 1. For Resident #18, the facility staff failed to follow up on a pharmacy review dated 02/22/19. The clinical record review revealed that Resident #18 had been admitted to the facility on 07/17/18. Diagnosis included, but were not limited to, diabetes, anxiety disorder, hypertension, and atrial fibrillation. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/22/19 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points. The clinical record included a "CONSULTANT PHARMACIST REVIEW" dated 02/22/19 that indicated the pharmacist had made a recommendation regarding this Resident. The clinical record did not include the recommendation. On 04/10/19 at 2:00 p.m., the ADON (assistant director of nursing) was notified of the missing pharmacy review. The facility provided the surveyor with a copy of a "Consultant Pharmacist Recommendation to	F 756	1. Facility Medical Director notified of pharmacy recommendations for resident #18 and 39. No new orders. 2. An audit of pharmacy recommendations for the last 30 days completed to ensure Medical Director review and necessary follow up. No other issues identified. 3. Licensed nursing staff inserviced by DON and designee regarding the need for pharmacy recommendations to be reviewed by Medical Director for necessary follow up. A monthly audit of pharmacy recommendations to be completed by DON and designee to ensure recommendations receive Medical Director review. This audit will be completed for a period of 90 days. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary. 5. 5/18/2019	

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Physician" dated 02/22/19 regarding a GDR (gradual dose reduction) in reference to the Residents antipsychotic medication Abilify. This recommendation was unsigned by the physician and there had been no change in the Residents dosage since this pharmacy review.

On 04/10/19 at 3:30 p.m., the ADON verbalized to the surveyor that this Resident was a VA (veterans administration) patient and they (the facility) were under the impression that the VA was following this medication.

The administrative staff were notified of the issue regarding the Residents antipsychotic medication abilify during a meeting with the survey team on 04/11/19 at 12:45 p.m.

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

2. For Resident #39, the facility staff failed to provide evidence that the medical director had reviewed a pharmacy recommendation for 08/15/18.

The clinical record review revealed that Resident #39 had been admitted to the facility 10/07/14. Diagnoses included, but were not limited to, acute/chronic respiratory failure, hypertension, chronic obstructive pulmonary disease, and cerebrovascular disease.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/18/19 included a BIMS (brief interview for mental status) summary score of 00.

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The clinical record did not include any pharmacy reviews prior to 02/201/9. When the facility provided the surveyor with the pharmacy reviews, it was noted that the pharmacist had made a recommendation for the month of August 2018. This recommendation was not included in the Residents clinical record.

On 04/10/19 at 4:59 p.m., the ADON (assistant director of nursing) verbalized to the surveyor that they had reached out to the pharmacist regarding the recommendation.

The facility provided the surveyor with a copy of a "Consultant Pharmacist Recommendation to Physician" form dated 08/15/18 in regards to the Residents prn (as needed) haldol (haloperidol) and compazine orders. This form read in part, " ...THESE MEDICATION ORDERS NEED TO BE STOPPED ON 8/28/18 AND IF TO CONTINUE, PROVIDER MUST EVALUATE RESIDENT AND WRITE A NEW 14 DAY ORDER ..."

The facility was unable to provide any verification that the physician/medical director had reviewed this recommendation.

On 04/11/19 at 10:43 a.m., the ADON stated that when the Resident began receiving hospice services (08/11/18) several orders had been written and changed.

The facility provided the surveyor with a copy of an email they had sent to the contracting hospice company regarding transcribing orders in the long-term care setting concerning regulations.

The facility provided the surveyor with paperwork

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F 756	Continued From page 14 to indicate the Residents haldol had been changed from prn to scheduled on 08/17/18 and the compazine had been discontinued on 11/09/18. The administrative staff were notified of the above during a meeting with the survey team on 04/11/19 at 12:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		5/17/19

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F 761	Continued From page 15 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to provide privacy and confidentiality of 1 of 24 residents in the survey sample. (Resident #76) The findings included: The facility staff failed to provide privacy and confidentiality for Resident #76 during the medication observation made by the surveyor on 4/10/19. Resident #76 was admitted to the facility on 3/15/19 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary artery disease, high blood pressure, diabetes, seizure disorder, anxiety disorder, depression and manic depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #75 was also coded as requiring limited assistance of 1 staff member for dressing, personal hygiene and bathing. During the medication observation on 4/10/19 at 8:26 am, the surveyor observed LPN (licensed practical nurse) #1 went into room 110 to wash her hands. The laptop on top of the medication cart was left open and medical information could be readily visible to anyone in the hallway at that time. The nurse could not view the medication cart's laptop while she was in the bathroom.	F 761	1. LPN #1 has been educated on locking laptop screen when stepping away from medication cart in order to ensure privacy of patient medical information. 2. An audit of medication pass was completed by Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure licensed nursing staff locks laptop screens before leaving medication carts in order to ensure privacy of patient medical information. No other issues identified. 3. Licensed Nursing Staff to be inserviced by DON or designee regarding the protection of privacy of patient medical information during medication passes. A random audit of medication passes across all shifts to be completed by DON or designee to ensure laptops are locked by licensed nursing staff before stepping away from medication cart to ensure privacy of patient medical information. This audit is to be completed three times per week for a period of eight (8) weeks. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary.	

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F 761	Continued From page 16 The surveyor asked LPN #1how she is to leave the computer screen when she walks away from the medication cart. LPN #1 stated, "I'm suppose to lock the screen." The surveyor notified LPN #1 that she did not lock her screen when she went into the bathroom in the resident's room at 8:26 am. The surveyor notified the administrative team at 1 pm of the above documented observation. At 3:55 pm, the surveyor requested and received the facility's policy titled "Confidentiality of Information and Personal Privacy" which read in part, " ...The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records ...Access to resident personal and medical records will be limited to authorized staff and business associates ..." No further information was provided to the surveyor prior to the exit conference on 4/11/19.	F 761		
F 812 SS=F	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.	F 812		5/17/19

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F 812	Continued From page 17 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility failed to prepare, store, and distribute food in a manner that would prevent foodborne illnesses. The findings included: The dietary department included expired milk and mustard. One handwashing sink did not have hot water available and the machine used to heat the dome lids (pellet dispenser) for food plates was not in working order. On 04/09/19 beginning at approximately 9:30 a.m., the surveyor toured the dietary department with the dietary manger. Upon entering the dietary department, the surveyor attempted to wash their hands in one of two sinks. Sink #1 did not have any hot water available for hand washing. The dietary manager verbalized to the surveyor that the machine used to warm the dome lids for the food trays had been broken a couple of months. The walk in fridge included a large container of mustard with a best by date of 09/07/18 and a full gallon of milk with an expiration date of 04/08/19.	F 812	1. All food items identified as being out of date were discarded on 4/9/2019. 2. An audit of food storage areas completed by Dietary Manager on 4/9/2019 to ensure proper labeling and storage. No other issues identified. 3. Dietary staff inserviced on labeling and storage of food items by dietary District Manager. A weekly audit of food storage areas to be completed by Dietary Manager or designee to ensure proper labeling and storage of food items. This audit will be completed for eight (8) weeks. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary.	

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F 812	Continued From page 18 The milk cooler included 5-half pints of milk with an expiration date of 04/07/19. Upon exiting the dietary department, the surveyor notified the administrator of the issues identified in the dietary department. On 04/09/19 at 12:36 p.m., the dietary manager stated the sink had been fixed. The surveyor checked sink #1 with no further issue identified. On 04/10/19 at 12:53 p.m., the administrator, DON (director of nursing), and ADON (assistant director of nursing) were notified of the issue in the dietary department. On 04/11/19 at 11:10 a.m., the maintenance director stated he had adjusted the mixing valve to a temperature of 110 degrees. Prior to the exit conference, the administrator provided the surveyor with a copy of a quote from a contracting facility for the pellet dispenser system. This quote was dated 03/28/19. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		5/17/19

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F 842	Continued From page 19 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 20 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate medical record for 1 of 24 residents in the survey sample (Resident #76). The findings included: The facility staff failed to maintain a complete and accurate medical record for Resident #76. Resident #76 was admitted to the facility on 3/15/19 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary artery disease, high blood pressure, diabetes, seizure disorder, anxiety disorder, depression and manic depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/19, the resident was coded as having a BIMS (Brief Interview for Mental Status)	F 842	1. EMAR for resident #76 “unlocked” by assigned 11-7 nurse who had locked in error. This allowed 703 nurse to document. Surveyor was provided evidence of updated EMAR during survey. 2. Nursing Administration reviewed the EMAR of all other active residents to identify locked or unsigned records. No other issues identified. 3. Licensed nursing staff inserviced by DON and designee related to shift change review of EMAR for documentation compliance of no locked or unsigned records. DON and designee to complete audit of EMAR for locked/unsigned records three (3) times a week for a period of eight (8) weeks. 4. The results of this audit will be brought to facility Quality Assurance and	

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F 842	Continued From page 21 score of 15 out of a possible score of 15. Resident #75 was also coded as requiring limited assistance of 1 staff member for dressing, personal hygiene and bathing. On 04/11/19 at 09:47 am, the surveyor received the documentation on the MAR (Medication Administration Record) for April 2019 for this resident. For April 10th, the day shift nurse could go in to the computer system for the medicines to be administrated. The surveyor observed the nurse giving the residents medication at 9 am. Later the surveyor reviewed the MAR and the medications were not documented as being done or given to the resident. The surveyor informed the DON (director of nursing) of this finding at approximately 2:30 pm. The DON stated, "I found this at 7:30 am this morning. The night shift nurse locked the MAR and the day shift nurse cannot document the medications as being given until the night shift nurse comes to the facility and unlocks the computer." The surveyor notified the administrative team of the above documented findings on 4/11/19 at approximately at 1:30 pm. No further information was provided to the surveyor prior to the exit conference on 4/11/19.	F 842	Performance Improvement for review and revision as necessary.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services	F 849		5/17/19

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through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical,

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mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must

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report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners

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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 849	Continued From page 25 participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to coordinate resident care in regards to hospice services for 1 of 24 residents in the survey sample (Resident	F 849	F849 1. Hospice documentation for resident #81 was obtained and placed in resident's clinical record on 4/11/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 04/11/2019

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F 849	Continued From page 26 #81). The findings included: The facility staff failed to have Hospice documentation in the facility in which the resident resides for Resident #81. Resident #81 was admitted to the facility on 3/18/19 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, arthritis, Alzheimer's disease, anxiety disorder and depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/25/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 4 out of a possible score of 15. Resident #81 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. On 4/9/19 at 1:00 pm, the surveyor reviewed the clinical record of Resident #81 that was in the computer. At 1:50 pm, the surveyor went on to the nursing unit and reviewed the resident's paper clinical record. The surveyor could not find Hospice documentation in either areas. At 2:05 pm, LPN (licensed practical nurse) #1 brought resident's clinical record to the surveyor in the conference room. LPN #1 stated that the resident had been transferred from the assisted living to long-term care. "All the hospice records were sent and filed in the assisted living building and not here. I just had to run over and got them for us." The surveyor notified the administrative team of the above documented findings on 4/10/19 at	F 849	2. An audit of all residents currently receiving hospice services was conducted by administrative nursing staff to ensure hospice records are present. No other issues identified. 3. Executive Director to in services to all contracted hospice service providers regarding hospice agreement compliance to include inclusion of hospice records to facility's medical records. Medical Records personnel to conduct weekly audit of current residents receiving hospice services to ensure presence of medical records. Audit to be completed for a period of eight (8) weeks. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary.	

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F 849	Continued From page 27 approximately 3:55 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/11/19.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		5/17/19

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F 880	Continued From page 28 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow infection control guidelines in the course of the medication administration observation on 1 of 2 nursing units in the facility (Allegany Nursing	F 880	F880 1. This incident could not be corrected. LPN #2 inserviced regarding facility policy on Administrating Medications. 2. A random audit of medication passes	

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F 880	Continued From page 29 Unit). The findings included: On 04/10/19 08:56 am, the surveyor observed LPN (licensed practical nurse) #2 standing at the medication cart on the Alleghany unit hallway. LPN #2 prepared medications and while doing so, popped the pill out of the medication card system into her bare hands. Then the nurse placed the medication in a medicine cup and administrated to a resident. At 9:20 am, the surveyor asked LPN #2 how she was to handle the medication when it was being prepared to administer to a resident. LPN #2 stated, "I place a medication cup behind the card and pop the pills in that." The surveyor notified the nurse that she did not do this when preparing medications to be administrated to a resident and that she used her bare hands to place the medication in and then into the medicine cup. LPN #2 stated, "I'm just so nervous and I didn't even know that I did that." The surveyor asked and received the facility's policy on "Administrating Medications" which read in part, " ...Staff shall follow established infection control procedures ...for the administration of medications ..." On 4/10/19 at 3:55 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/11/19.	F 880	completed by DON and designee to ensure infection control guidelines are followed in accordance with regulation and company policy. No other issues identified. 3. Licensed Nursing Staff inserviced by DON and designee regarding infection control guidelines related to administrating medications. A weekly audit of medication passes to be conducted by DON or desginees to ensure infection control guidelines are followed in accordance to regulation and company policy. This audit to be completed for a period of eight (8) weeks. 4. The results of this audit will be brought to facility Quality Assurance and Performance Improvement for review and revision as necessary.	