STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH AND REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

(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 12/04/17 through 12/07/17. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 12/04/17 through 12/07/17. The facility was not in compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 19 current Resident reviews three closed record reviews.	F 000		
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	F 623		1/2/18

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

Electronically Signed | 12/19/2017

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paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§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

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F 623	Continued From page 2	F 623		

hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

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F 623	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide notice of discharge for two of 22 residents in the survey sample, Resident # 13 and Resident # 53. Resident #53 was admitted to the facility on 09/05/17, with diagnoses of pelvic (vaginal) cancer, bipolar disorder, MDD (major depressive disorder) and DM (diabetes mellitus. The resident had a 5 day MDS (minimum data set) dated 09/12/17 that assessed the resident as a 15, indicating the resident was cognitively intact for daily decision making skills. During clinical record review on 12/06/17 at 09:38 AM, the record revealed that the resident was admitted to the facility on 09/05/17 from home. According to the clinical record the resident was receiving HH (home health) and was under care of HH (home health) prior to admission to the facility. The resident was brought in by husband. Per NN (nursing notes) the resident had an intravenous port in her RU (right upper) chest and had a urostomy in the RLQ (right lower quadrant) with foley bag attached. Resident with admitting dx (diagnoses) of malignant neoplasm of the vagina, intrapelvic lymph nodes and recent hysterectomy. The resident only resided in the facility for a short time and was discharged from the facility on 09/15/17 for a change in condition. The resident's record was reviewed for notification before transfer and was not found.	F 623	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain incompliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F623 1. Resident #53 no longer resides in the facility. The responsible party for resident #13 as well as the ombudsman were notified in writing of the emergent discharge that occurred on 8/18/2017 on 12/19/2017. 2. An audit was conducted by the director of nursing to identify emergent discharges in the last four weeks to provide written notice to responsible parties and the ombudsman. 3. Staff Development Coordinator will educate nursing administration and receptionist to initiate written notification to responsible parties and the ombudsman following an emergent transfer. 4. Director of Nursing or designee will review all emergent transfers weekly for four weeks to ensure written notice has been provided to the responsible party and ombudsman. 5. Any discrepancies will be brought to the QA meeting and addressed as	

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F 623	Continued From page 4 On 12/06/17 11:38 AM the CNC (corporate nurse consultant) was interviewed. The CNC stated that the facility has not been giving written notification in regards to transfer and/or discharge for residents, but stated we will in the future. No further information and/or documentation was presented prior to the exit conference on 12/07/17 at 10:30 a.m. 2. Resident #13's responsible party or ombudsman was notified in writing in a timely manner of a hospitalization. Resident #13 was admitted to the facility on 10/9/14 with a readmission on 8/18/17 with diagnoses including left hip fracture. The most recent MDS (minimum data set) was a quarterly day assessment with an ARD (assessment reference date) of 9/18/17. Resident #13 was assessed as being cognitively impaired. Resident #13's electronic record was reviewed on 12/4/17 and documented, via progress note dated 8/18/17, that Resident #13 had fallen and complained of pain to hip. Resident #13 was admitted to the hospital due to a fractured left femur. Review of Resident #13's medical record did not indicate that the ombudsman or responsible party was notified in writing as of the time of survey.	F 623	needed. Date of compliance: January 2, 2018.	

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F 623	Continued From page 5 On 12/6/17 the facilities nurse consultant was asked to provide evidence that the Resident's responsible party and the ombudsman was notified in writing of Resident #13's hospitalization. On 12/06/17 11:31 AM the nurse consultant verbalized that the facility does not report to Ombudsman or RP (responsible party) in writing and was not aware of this practice. On 12/06/17 04:28 PM end of day staff meeting this surveyor informed DON (director of nursing) and Administrator of not notifying Ombudsman and RP of transfer to hospital in writing. No other information was presented prior to exit conference on 12/7/17.	F 623		
F 645 SS=D	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	F 645		1/2/18

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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 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

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F 645	Continued From page 7 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 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 interview and clinical record review, the facility staff failed to ensure one of 22 residents had a preadmission screening for PASARR, Resident #48. The findings include: Resident # 48 was admitted to the facility originally on 06/03/16, with the most current readmission on 09/08/17. The resident's diagnoses included, but were not limited to: pneumonia, septicemia and paranoid schizophrenia. Resident # 48's significant change MDS (minimum data set) assessment dated 09/21/17 assessed the resident as having short and long term memory impairment with severe impairment with daily decision making skills. The resident's MDS did not indicate that a ASA level I or level II had been completed on this resident. On 12/05/17 08:21 am the facility's SW (social worker) was interviewed regarding a PASARR. The SW was informed that a level I or a level II could not be found on the resident. The SW stated that she will look to make sure the resident	F 645	1. A screening for PASARR level I and level II was initiated for resident #48 while surveyors were onsite. It was obtained on 12/18/2017 and was scanned into the medical record. 2. An audit was conducted by the director of nursing to identify any current resident with the diagnosis of paranoid schizophrenia to ensure they have a PASARR level I and level II completed and scanned into the medical record. 3. Staff Development Coordinator will educate admissions director and discharge planner that any new admission with the diagnosis of paranoid schizophrenia must have a PASARR level I and level II screening in place and must be scanned into the medical record. 4. Admissions director and/or discharge planner will ensure that any new admissions with the diagnosis of paranoid schizophrenia will have a PASARR level I and level II in place prior to admission to the facility weekly for four weeks. 5. Any discrepancies will be brought to the QA meeting and addressed as needed. Date of compliance: January 2, 2018.	

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doesn't have one. The resident has a dx (diagnosis) of paranoid schizophrenia.

On 12/05/17 02:59 PM the administrator was interviewed regarding a PASARR level I or level II, the administrator stated that the SW had called the hospital where the resident was prior to admission here and at this time, can't come across one, but is still looking.

On 12/06/17 08:22 AM The administer stated that the resident did not have PASARR I or II, and does not know when the resident acquired the dx of paranoid schizophrenia. The administrator presented a UAI (uniform assessment instrument).

On 12/06/17 10:30 AM the policy was presented on the Level I and Level II PASARR by the DON (director of nursing). The policy titled, "Level I PASARR" documented "...prior to arrival of a planned admission the discharge planner will collaborate with the admissions director to preview the transferring hospital's Level I PASARR...prior to patient's discharge to the center...if a Level I PASARR is missing from the transferring hospital's preadmission paperwork...contact the transferring hospital...when the patient is admitted to the center...scan and upload the...provided PASARR into the patients electronic medical record no later than five (5) days after the patient is admitted to the center..."

The facility staff could not determine if the resident had a Level I or a Level II PASARR.

No further information and/or documentation was presented prior to the exit conference on

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F 645	Continued From page 9 12/07/17 at 10:30 a.m.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		1/2/18

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F 656	Continued From page 10 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and clinical record review, the facility staff failed for one of 22 residents in the survey sample (Resident # 21) to, (A) develop a plan of care for the use of a Broda chair, and (B) failed to implement the resident's plan of care addressing call bell use. The findings were: A. Resident # 21 in the survey sample, a 93 year-old female, was admitted to the facility on 3/20/14 with diagnoses that included Alzheimer's Disease, bipolar disorder, encephalopathy, diabetes mellitus, atherosclerotic heart disease, hypertension, gastroesophageal reflux disease, anxiety disorder, and dysphagia. According to an Annual Minimum Data Set with an Assessment Reference Date of 10/13/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. During the orientation tour at 11:00 a.m. on 12/4/17, Resident # 21 was observed in her room, seated in a Broda chair. (A Broda chair is a high back wheel chair with foot supports and a tilting back.) The chair was positioned at the foot of the resident's bed. At 7:45 a.m. on 12/5/17, the resident was observed in the Dining Room,	F 656	1. A device assessment was completed for the use of the high back wheelchair and added as an intervention to the careplan for resident #21 and the call bell was placed within reach while surveyors were onsite. 2. An audit was conducted by the director of nursing to identify any current resident in a high back wheelchair to ensure they have an appropriate device assessment in place and that it is added to the careplan as an intervention. An audit was conducted by the director of nursing to ensure all current residents had their call bell within reach while in their room on 12/19/2017. 3. Staff development coordinator will educate nursing staff related to proper assessment of the use of a high back wheelchair and adding it as an intervention to the careplan and ensuring residents have their call bell within reach when they are in their room. 4. Director of nursing or designee will monitor any resident with a new high back wheelchair to ensure that an appropriate device assessment has been completed and that the device has been added as an intervention to the careplan weekly for four weeks. Director of nursing or designee will round to ensure that	

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seated in the Broda chair and being fed breakfast. After breakfast the resident was returned to her room in the Broda chair which was then positioned at the foot of her bed.

A thorough review of Resident # 21's care plan failed to reveal any problems, goals, or interventions related to the use of the Broda chair.

At 1:45 p.m. on 12/6/17, the Director of Nursing (DON) was interviewed regarding Resident # 21's use of the Broda chair. Asked why the resident was in the Broda chair, the DON responded, "It was initiated by OT (Occupational Therapy) for poor trunk control during feeding." When it was pointed out by the surveyor that there was no mention of the Broda chair in the resident's care plan, the DON said, "It should be in her care plan."

The DON was asked if there was an assessment for the resident's use of the Broda chair. The DON said there was and that she would get it for the surveyor. The DON returned and gave the surveyor the following Progress Note dated 2/10/17:

"Resident sitting in dining room, this nurse approached resident to administer morning meds (medications), resident began coughing, cough sounded very wet, a thick frothy liquid was coughed up into her mouth, she attempted to swallow and began cough again. Resident seemed to not be able to hold head straight, neck was noted to be extended. This nurse assisted her head to the upright position and resident was able to swallow fluids coughed up. NP (Nurse Practitioner) notified, per NP resident was placed

residents in their room can reach their call bell three times a week for four weeks.
5. Any discrepancies will be brought to the QA meeting and addressed as needed. Date of compliance: January 2, 2018.

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APPOMATTOX HEALTH AND REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 656	Continued From page 12	F 656		

in Broda chair with high back to help keep neck straight and avoid neck extension. Resident is alert, easy arouse. Will continue to monitor."

At 2:20 p.m. on 12/6/17, the Physical Therapist (PT) was asked who conducts assessments on residents for the use of a Broda chair. The PT indicated the assessment would be conducted by OT. At 2:30 p.m. on 12/6/17, the Occupational Therapist was asked about the assessment for Resident 21's use of the Broda chair. The Occupational Therapist said she would have a CNA (Certified Nursing Assistant) locate the assessment.

At approximately 3:00 p.m. on 12/6/17, the surveyor returned to the OT office. The Occupational Therapist said Resident 21's Broad chair assessment was contained in the Progress Note entry dated 2/10/17, which included the notation, "...NP (Nurse Practitioner) notified, per NP resident was placed in Broda chair with high back to help keep neck straight and avoid neck extension...."

B. During the orientation tour at 11:00 a.m. on 12/4/17, Resident # 21 was observed in her room, seated in a Broda chair. The chair was positioned at the foot of the resident's bed. The resident's call bell was in the middle of the her bed and out of her reach. CNA # 2, who was in the room at the time of the observation, was asked if the resident could reach the call bell. CNA # 2 said that she could not reach it, and that she could not use it. CNA # 2 made no effort to place the call bell within the resident's reach.

At 7:45 a.m. on 12/5/17, the resident was

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F 656	Continued From page 13 observed in the Dining Room, seated in the Broda chair and being fed breakfast. After breakfast the resident was returned to her room in the Broda chair, which was then positioned at the foot of her bed. The resident's call bell was positioned at the head of her bed and under her pillow. CNA # 1, who brought the resident back from breakfast made no effort to place the call bell within Resident # 21's reach. Review of Resident # 21's care plan revealed the following problem, dated 4/29/14, "The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Dementia, Limited Mobility." One of the interventions for the stated problem was, "Encourage resident to use bell to call for assistance." The resident's care plan also included a second problem, dated 6/19/15, and revised on 10/20/17, "The resident is at risk for falls r/t Unaware of safety needs, Wandering, Gait/balance problems." One of the interventions for the stated problem was "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed." The findings were reviewed during a meeting at 4:15 p.m. on 12/6/17 that included the Administrator, the DON, the Corporate Nurse Consultant, and the survey team.	F 656		
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	F 657		1/2/18

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F 657	Continued From page 14 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the CCP (comprehensive care plan) for two of 22 residents in the survey sample, Residents #21, and # 26 and failed to invite one of 22 residents (Resident # 15) to participate in a care plan meeting. 1. For Resident # 21, the facility staff failed to revise the care plan to address wandering. 2. The facility staff failed to review and revise the CCP (comprehensive care plan) to ensure	F 657	1. The comprehensive careplan for resident #21 was updated to address wandering as a focus problem. The comprehensive careplan for resident #26 was updated to reflect that oxygen administration and equipment is maintained by the licensed staff. Resident #15 will be invited in advance, in writing to his next quarterly careplan. 2. An audit was conducted by the director of nursing to identify any current resident who is a wander risk to ensure it is reflected on the comprehensive careplan. An audit was conducted by the	

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F 657	Continued From page 15 Resident # 26's oxygen administration and equipment were maintained by nurses. The findings include: 1. For Resident # 21, the facility staff failed to revise the care plan to address wandering. Resident # 21 in the survey sample, a 93 year-old female, was admitted to the facility on 3/20/14 with diagnoses that included Alzheimer's Disease, bipolar disorder, encephalopathy, diabetes mellitus, atherosclerotic heart disease, hypertension, gastroesophageal reflux disease, anxiety disorder, and dysphagia. According to an Annual Minimum Data Set (MDS) with an Assessment Reference Date of 10/13/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. Under Section G (Functional Status), the resident was assessed as walking in her room or the corridor with one person physical assist only once or twice during the seven-day look back period. For locomotion on and off the unit, the resident was assessed as needing extensive assistance with one person physical assist. Review of Resident # 21's care plan revealed the following problem, dated 10/10/14, "The resident is an elopement risk/wanderer r/t (related to) dementia, resident wanders aimlessly, impaired safety awareness, disoriented to place." Further review of the resident's Annual MDS under Section E (Behavior), at Item E0900 -	F 657	director of nursing to identify any current resident who prefers to be on an oxygen tank versus a concentrator to ensure the comprehensive careplan reflects that the licensed staff will maintain oxygen administration and equipment. An audit was conducted by the director of nursing to ensure any resident with a comprehensive careplan review meeting was invited to participate on 12/19/2017. 3. Staff development coordinator will educate licensed staff on how to appropriately update the comprehensive careplan to reflect residents who are a wander risk and to reflect that the licensed staff will maintain oxygen administration and equipment for residents who prefer to be on an oxygen tank versus a concentrator. Staff development coordinator will educate MDS coordinator to invite residents, as well as responsible parties, to the comprehensive careplan meeting in advance, in writing. 4. Weekly for four weeks the director of nursing or designee will monitor to ensure any resident assessed as a wander risk has that appropriately reflected on the comprehensive careplan and monitor current residents who prefer to be on an oxygen tank versus a concentrator to ensure the comprehensive careplan reflects that the licensed staff will maintain oxygen administration and equipment. Weekly for four weeks the director of nursing or designee will monitor to ensure that residents with comprehensive careplan reviews have been invited to attend in advance, in writing. 5. Any discrepancies will be brought to	

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F 657	Continued From page 16 Wandering, revealed the resident did was not assessed as exhibiting wandering behaviors. Review of Quarterly MDS's dated 4/14/17 and 7/14/17, also revealed the resident was not assessed as exhibiting wandering behaviors. The findings were reviewed during a meeting at 4:15 p.m. on 12/6/17 that included the Administrator, the DON, the Corporate Nurse Consultant, and the survey team. 2. The facility staff failed to review and revise the CCP (comprehensive care plan) to ensure Resident # 26's oxygen administration and equipment were maintained by nurses. Resident #26 CCP (comprehensive care plan) was not updated to ensure that facility staff would maintain oxygen administration and equipment. Resident # 26 was admitted to the facility on 11/14/16 with diagnoses including, but not limited to: pneumonia, COPD (chronic obstructive pulmonary disease), anxiety disorder and SIRS (systemic inflammatory response syndrome) Respiratory Care On 12/04/17 12:17 PM Resident # 26 was observed in her room. The resident had a portable oxygen tank attached to the back of her w/c (wheelchair) and the dial was set on 2LPM (liters per minute) but the portable tank was actually empty. The oxygen tubing was attached to the portable tank and applied to the resident via N/C (nasal cannula), the resident states her breathing is ok.	F 657	the QA meeting and addressed as needed. Date of compliance: January 2, 2018.	

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On 12/04/17 12:54 PM, the resident was observed again, the O2 was still empty. The nurse, LPN (licensed practical nurse) # 1 was asked to check the resident's O2 saturation.

12/04/17 12:55 PM LPN # 1 checked the resident's O2 saturation, the reading was 82% and raised to 83%.

12/04/17 12:59 PM The resident's O2 sat increased to 88%.

12/04/17 01:00 PM The resident's O2 sat increased to 90%.

LPN # 1 stated that the resident usually tells when staff when she needs a new oxygen tank. The LPN was asked how the resident would know that the oxygen tank is empty if the resident's portable oxygen tank is attached to the back of the wheelchair and can't actually see the tank. The LPN made no comment.
Resident # 26's clinical record was reviewed. Current physician's orders revealed that the resident did not even have an active order for oxygen. The orders included, "...change oxygen tubing weekly on concentrator and O2 tank...COPD...Oxygen tubing change weekly on 11-7 shift Friday..." There was not actual order for the oxygen.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...respiratory infection...assess respiratory status as needed...O2 as ordered...treatments as ordered...altered respiratory status/difficulty breathing related to COPD...administer medication/puffers as ordered, monitor effectiveness...monitor signs and symptoms of

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respiratory distress and report...OXYGEN SETTINGS: O2 via NC @ 2-4 L/M...resident wishes to be off oxygen concentrator and on portable oxygen tank to move about facility freely, when not sleeping. She [resident] informs nursing staff when tank is empty and nurses get her new tank as needed..."

On 12/06/17 01:30 PM the resident stated that approximately an hour ago the resident noticed that she was having a little trouble breathing, "I [resident] pulled it out of my nose and stuck it to my ear and noticed no air was coming out and put back on my face, went to my nurse and she gets the key and goes gets another oxygen tank (portable) and put it on back of my w/c and hooks me back up." The resident was asked if the nurse checked her oxygen saturation, the resident stated, "No."

No documentation was found in the resident's record to indicate that nursing staff had checked the resident's O2 saturation.

12/06/17 02:17 PM A policy on O2 was presented by the DON. The policy documented that, "...the licensed nurses will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician's orders and in accordance with standards of nursing practice...general documentation guidelines...oxygen delivery flow rate, method of delivery...saturation levels if indicated...document oxygen saturation levels and/or vital signs on nurse's note as indicated and any unusual findings and follow-up interventions including physician and responsible party notification.

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No further information and/or documentation was presented to evidence that the resident's CCP was updated to ensure nursing staff were assessing and maintaining Resident # 26's oxygen administration and oxygen equipment.

3. Resident #15 was not invited to participate in his care plan meeting held on 10/3/17.

Resident #15 was admitted to the facility on 12/29/14 with a re-admission on 7/4/16. Diagnoses for Resident #15 included diabetes, bipolar disorder, high blood pressure, benign prostatic hypertrophy and history of small bowel obstruction. The minimum data set dated 9/20/17 assessed Resident #15 as cognitively intact.

On 12/04/17 at 4:06 p.m. a private resident interview was conducted with Resident #15 concerning quality of life in the facility. During the interview Resident #15 stated he did not participate in his last care plan meeting and did not recall being invited to any of his care conferences.

Resident #15's clinical record documented no reasons why the resident was unable to attend or participate in his care plan meeting. There was no documentation of any invitation or interventions implemented to encourage the resident to attend the care conference. The record documented an undated letter addressed to the resident's son inviting the son to participate in the care plan conference scheduled for 10/3/17.

On 12/05/17 at 2:55 p.m. the facility's social worker was interviewed about Resident #15's

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F 657	Continued From page 20 participation in the care plan meeting held on 10/3/17. The social worker stated the MDS coordinator sent care plan invitation letters to the responsible parties listed for residents. Concerning Resident #15, the social worker stated a letter was sent to the resident's son prior to the care plan meeting held on 10/3/17. The social worker stated no invitation letter was sent to the resident because the son was listed as the resident's responsible party (RP). The social worker stated notifications about care plan conferences were not sent to residents unless they were listed as their own responsible party. On 12/05/17 at 3:38 p.m. the MDS coordinator was interviewed about Resident #15's lack of invitation and participation in the care plan meeting held on 10/3/17. The MDS coordinator stated she sent a letter about 7 to 10 days in advance of the meeting to the resident's son. The MDS coordinator stated, "We do not typically send letters to residents unless they are listed as their own RP." The MDS coordinator stated Resident #15 was not notified in advance of his last care conference held on 10/3/17 and did not attend and/or participate. These findings were reviewed with the administrator and director of nursing during a meeting on 12/6/17 at 4:30 p.m.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		1/2/18

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F 695	Continued From page 21 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review the facility staff failed to ensure one of 22 residents (Resident # 26) was provided oxygen therapy per the resident's CCP (comprehensive care plan) and resident assessment to maintain an acceptable oxygen saturation level. The findings include: Resident #26 was admitted to the facility on 11/14/16 with diagnoses including, but not limited to: pneumonia, COPD (chronic obstructive pulmonary disease), anxiety disorder and SIRS (systemic inflammatory response syndrome) On 12/04/17 12:17 PM Resident # 26 was observed in her room. The resident had a portable oxygen tank attached to the back of her w/c (wheelchair) and the dial was set on 2LPM (liters per minute) but the portable tank was actually empty. The oxygen tubing was attached to the portable tank and applied to the resident via N/C (nasal cannula), the resident states her breathing is ok. On 12/04/17 12:54 PM, the resident was observed again, the O2 was still empty. The nurse, LPN (licensed practical nurse) # 1 was asked to check the resident's O2 saturation. 12/04/17 12:55 PM LPN # 1 checked the	F 695	1. Oxygen saturation for resident #26 was checked by licensed staff while surveyors were onsite and a new oxygen tank was provided immediately. 2. An audit was conducted by the director of nursing to identify any current resident who prefers to be on an oxygen tank versus a concentrator to ensure there is an active order in the treatment administration record to check the resident□s portable oxygen tank to ensure it has acceptable amount of oxygen and to assess resident□s respiratory status to ensure acceptable oxygen saturation level. 3. Staff development coordinator will educate licensed staff on appropriate assessment of resident who prefers to be on an oxygen tank versus a concentrator to ensure there is an active order in the treatment administration record to check the resident□s portable oxygen tank to ensure it has acceptable amount of oxygen and to assess resident□s respiratory status to ensure acceptable oxygen saturation level. 4. Weekly for four weeks the director of nursing or designee will monitor the treatment administration record to ensure there is an active order to check the resident□s portable oxygen tank to ensure it has acceptable amount of oxygen and to assess the resident□s	

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F 695	Continued From page 22 resident's O2 saturation, the reading was 82% and raised to 83%. 12/04/17 12:59 PM The resident's O2 sat increased to 88%. 12/04/17 01:00 PM The resident's O2 sat increased to 90%. LPN # 1 stated at this time, that the resident usually tells when staff when she needs a new oxygen tank. The LPN was asked how the resident would know that the oxygen tank is empty if the resident's portable oxygen tank is attached to the back of the wheelchair and can't actually see the tank. The LPN made no comment. Resident # 26's clinical record was reviewed. Current physician's orders revealed that the resident did not even have an active order for oxygen. The orders included, "...change oxygen tubing weekly on concentrator and O2 tank...COPD...Oxygen tubing change weekly on 11-7 shift Friday..." There was not actual order for the oxygen. The resident's CCP (comprehensive care plan) was reviewed and documented, "...respiratory infection...assess respiratory status as needed...O2 as ordered...treatments as ordered...altered respiratory status/difficulty breathing related to COPD...administer medication/puffers as ordered, monitor effectiveness...monitor signs and symptoms of respiratory distress and report...OXYGEN SETTINGS: O2 via NC @ 2-4 L/M...resident wishes to be off oxygen concentrator and on portable oxygen tank to move about facility freely,	F 695	respiratory status to ensure acceptable oxygen saturation level and that it has been completed daily. 5. Any discrepancies will be brought to the QA meeting and addressed as needed. Date of compliance: January 2, 2018.	

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F 695	Continued From page 23	F 695		

when not sleeping. She [resident] informs nursing staff when tank is empty and nurses get her new tank as needed..."

On 12/06/17 01:30 PM the resident stated that approximately an hour ago the resident noticed that she was having a little trouble breathing, "I [resident] pulled it out of my nose and stuck it to my ear and noticed no air was coming out and put back on my face, went to my nurse and she gets the key and goes gets another oxygen tank (portable) and put it on back of my w/c and hooks me back up." The resident was asked if the nurse checked her oxygen saturation, the resident stated, "No."

No documentation was found in the resident's record to indicate that nursing staff had checked the resident's O2 saturation.

12/06/17 02:17 PM A policy on O2 was presented by the DON. The policy documented that, "...the licensed nurses will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician's orders and in accordance with standards of nursing practice...general documentation guidelines...oxygen delivery flow rate, method of delivery...saturation levels if indicated...document oxygen saturation levels and/or vital signs on nurse's note as indicated and any unusual findings and follow-up interventions including physician and responsible party notification."

No further information and/or documentation was presented prior to the exit conference on 12/07/17 at 10:30 a.m.

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F 804	Continued From page 24	F 804		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on resident interview and clinical record review the facility staff to ensure food palatability for one of 22 residents in the survey sample, Resident # 26. The findings included: Resident #26 was admitted to the facility on 11/14/16 with diagnoses including, but not limited to: pneumonia, COPD (chronic obstructive pulmonary disease), anxiety disorder and SIRS (systemic inflammatory response syndrome) Resident # 26 was interviewed on 12/06/17 10:21 AM 12/04/17 04:53 PM. The resident stated she had issues with food choices, stated that the staff serve the same foods over and over. Resident stated that butter beans and other types of foods are often not cooked properly, either undercooked or overcooked. The resident showed this surveyor a small bowl of butter beans that she stated, "you can't pierce these with your fingernail, they're not being completely cooked."	F 804	1. Resident #26 was offered alternative meal options while the surveyors were onsite. 2. An audit was conducted by the director of nursing to identify residents who prefer to consistently eat in room to ensure they are aware of alternate food options if they find their food not palatable. 3. Staff development coordinator will educate nursing and dietary staff about the availability of alternate food options for residents who do not find their food palatable. 4. Director of nursing or designee will round weekly to ensure residents who prefer to consistently eat in room are aware of alternate food options if they find their food not palatable for four weeks. 5. Any discrepancies will be brought to the QA meeting and addressed as needed. Date of compliance: January 2, 2018.	1/2/18

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	495188	A. BUILDING _____ B. WING _____	C 12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH AND REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 804	Continued From page 25 12/06/17 01:27 PM the resident reported that, "I have reported to several of the CNAs (certified nursing assistants) and they say they will let the nurses know, they don't ask me or my roommate what we want to eat, they serve it and that's what you get. I don't say nothing to her (the administrator) she will find some way to reverse it." 12/06/17 02:09 PM The resident and the resident's roommate stated that the staff do not come to ask them their food preferences/choices and they would prefer to pick what they eat and that neither of them are on a diet. On 12/06/17 4:30 p.m., the administrator was made aware and stated that the resident's who go to the dining room get to choose their food items from a list and further stated that it encourages the resident's to go to the dining room instead of eating in their rooms alone. The administrator was made aware that both resident's reported that they enjoy eating in their rooms, but would still like to have the ability to have a choice regarding food items. The administrator did not comment on the concerns from the resident regarding the food not being completely cooked. No further information and/or documentation was presented prior to the exit conference on 12/07/17 at 10:30 a.m.	F 804		
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	F 842		1/2/18

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F 842	Continued From page 26	F 842		

resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 27 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 22 residents in the survey sample. Resident 22's plan of care and a dietary note inaccurately documented the resident as receiving hospice care due to a terminal condition. The findings include: Resident #22 was admitted to the facility on 5/16/15 with diagnoses that included dementia with behaviors, hypothyroidism, high blood pressure, anemia, glaucoma and osteoporosis. The minimum data set (MDS) dated 10/13/17 assessed Resident #22 with severely impaired	F 842	1. The careplan and dietary note for resident #22 referencing inaccurate information were corrected while surveyors were onsite. 2. An audit was conducted by the director of nursing to identify residents with significant weight loss for the month of December to ensure accurate documentation was reflected in the careplan and dietary note. 3. Staff development coordinator will educate nursing administration and registered dietician about the importance of accurate documentation related to weight loss. 4. Director of nursing or designee will	

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F 842	Continued From page 28 cognitive skills. Resident #22's clinical record documented a dietary note dated 9/8/17 stating, "...Weight Change Note... Actual signif [significant] wt [weight] loss. Wt loss unavoidable d/t [due to] terminal condition, on hospice... Wt loss likely unavoidable...On hospice care..." Resident #22's current plan of care (revised 9/1/17) list the resident had significant weight loss and documented, "Wt loss unavoidable d/t [due to] terminal condition, on hospice." (sic) Resident #22's clinical record made documented no physician's order or care services provided by hospice. On 12/6/17 at 8:27 a.m. the licensed practical nurse (LPN #1) caring for Resident #22 was interviewed about hospice and any identified terminal illness. LPN #1 stated Resident #22 had no physician's order for hospice and had never been on hospice care. LPN #1 stated the facility's dietitian documented the notes and care plan entry referencing the terminal condition and hospice. On 12/6/17 at 9:58 a.m. the facility's registered dietitian (RD) was interviewed about the clinical documentation referencing a terminal condition and hospice care for Resident #22. After reviewing the care plan and note the RD stated the reference to hospice and a terminal condition were inaccurate. The RD stated, "That's a mistake on my part." The RD stated she had another resident on hospice care and got the residents mixed up when she was completing her documentation. The RD stated Resident #22's care plan and dietary note should have	F 842	review weight notes and careplan updates entered by the dietician to ensure accuracy of information weekly for four weeks. 5. Any discrepancies will be brought to the QA meeting and addressed as needed. Date of compliance: January 2, 2018.	

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F 842	Continued From page 29 referenced weight loss due to poor intake related to her progressive dementia. These findings were reviewed with the administrator and director of nursing during a meeting on 12/6/17 at 4:30 p.m.	F 842		