STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING ______ B. WING ______	C 02/16/2017

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ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/14/17 through 2/16/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of nineteen current resident reviews (Residents 1 through 18 and 22) and three closed record reviews (Residents 19 through 21).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		3/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/27/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the physician about a change of condition for one of 22 residents in the survey sample, Resident # 4. The facility staff failed to (A) notify the physician that Resident # 4 was constipated on several occasions and (B) failed to notify the physician of an impaction in November 2016.	F 157	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken 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	

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Findings include:

Resident # 4 was admitted to the facility on 02/19/16. Diagnoses for Resident # 4 included, but were not limited to: anemia, atrial fibrillation, CHF (congestive heart failure), blindness, chronic pain, DM (diabetes mellitus), end stage renal disease on hemodialysis, and constipation.

The most recent full MDS (minimum data set) was an annual assessment dated 12/13/16, which assessed the resident as having a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive to total assistance from staff with at least one staff person for physical assistance for all ADL's (activities of daily living), including hygiene and toileting. The resident also triggered in the CAAS (care area assessment summary) area for ADL's, urinary incontinence and indwelling catheter, and for dehydration (dehydration was not checked to care plan).

A quarterly MDS assessment was reviewed for comparison, dated 09/14/16. This MDS assessed the resident as having short and long term memory impairment with moderate impairment in daily decision making skills. This MDS additionally assessed the resident in section H0400. Bowel Incontinence as a "9", indicating "not rated, resident had an ostomy or did not have a bowel movement for the entire [previous] 7 days."

Resident # 4's clinical records were then reviewed to obtain information regarding the resident's past medical history.

F 157

corrected by the dates indicated.

F 157
1) The MD for Resident #4 has now been notified of all episodes of constipation and impaction noted during review.
2) All residents are at risk.
3) Staff Development Coordinator or designee will education all nurses administering medication regarding the following:
a. MD Notification with any episode of constipation.
b. MD Notification with any episode of impaction.
4) DON or designee will audit 100% of residents who have not had bowel movement in past 3 days for notification of MD, 5x per week for 2 weeks, then 20% of residents 5x per week for 2 weeks. Then quarterly during following QA meeting.

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A hospital discharge form dated 06/11/16 documented, "...R [right] sided abdominal mass c/w [consistent with] chronic stool impaction seen on previous imaging from 2012. Recommend aggressive bowel regimen and disimpacting as needed..."

The resident's bowel records were reviewed for the month of September 2016 to determine if the resident did in fact, go 7 days without a bowel movement.

According to the resident's bowel records, Resident # 4 did not have a BM (bowel movement) from September 8th through September 17th (10 days without a BM). No documentation was found in the nursing notes to evidence that the resident had a BM during this time frame.

Resident # 4's MARs (medication administration records) were then reviewed for the month of September 2016 and documented that the resident received the following scheduled medications daily, senna 8.6 mg (milligrams) two tablets at bedtime, lactulose 20 grams twice daily, and a fleets oil enema every 7 days (Friday).

The resident additionally had PRN (as needed) medications for bowel management, which included: a Bisacodyl suppository 10 mg every 6 hours as needed for bowel supplement, milk of magnesia 2000 mg every 24 hours as needed for constipation daily, and a mineral oil enema 4 ounces every 12 hours as needed.

According to the clinical record, none of the above PRN medications for bowel supplementation was administered to Resident #

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4. Additionally, no information or documentation could be located within the clinical record to evidence that the physician was made aware that Resident # 4 had not had a bowel movement in 10 days.

Further bowel records were reviewed for Resident # 4 and revealed that Resident # 4 had a small BM on 10/24/16 and did not have another BM until 10/31/16 (a 5 day period without a BM). The BM on 10/31/was documented as small, loose, diarrhea. The resident's next BM was documented on 11/04/16 (after the weekly scheduled Fleets enema).

Again, the resident did not receive any PRN medications for bowel supplementation.

A nursing note dated 11/05/16 and timed 12:07 a.m. documented, "At about 9:45 p.m. resident lay in bed with bed elevated to about 30 degree. Had a large amount of undigested food. Stomach rounded and firm c/o [complained of] stomach discomfort. Holding bottom from bed on exam hard BM @ [at] opening. BM removed order[ed] [sic] fleets [scheduled enema] given unable to administer more feces removed form [sic] rectum. Fleets given while at [sic] bottom of bed elevated [trendelenburg]. Waited about 5 min [minutes] then sat pt [patient] on shower chair taken to the bathroom. With very large am [amount] of hard, formed and soft BM results. ABD [abdomen] decreased in round and firmest [sic]. Will continue to monitor..."

Resident # 4 physician's orders were again reviewed and did not evidence that a physician's order had been obtained prior to disimpaction/digitally removing stool from the

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resident's rectum. The resident again did not receive any of the physician ordered, PRN medications to facilitate the resident in having a bowel movement and the physician was notified of the resident's condition.

A nursing note dated 11/05/16 and timed 1:04 p.m. documented, "....dialysis center reporting that pts BP [blood pressure] 221/112- temp 100.8 transported via EMS [emergency medical service]..."

The resident's hospital discharge summary documented the resident was admitted to the hospital on 11/05/16 and discharged on 11/08/16. The discharge summary documented, "...leukocytosis, abdominal pain, Acute on chronic constipation...per the SNF [skilled nursing facility] nurse, report from sign out was that he [resident] was very constipated and required aggressive disimpaction this morning...blood pressure was noted to be elevated at the SNF with a temperature of 100.2...exam notable for SBP [systolic blood pressure] 170-220, tachycardia, abdominal distention and tenderness...leukocytosis mild on presentation. Only abdominal pain positive on exam...resolved with treatment of constipation...Abdominal pain with history of chronic constipation: Disimpaction at SNF prior to admission, Had BM times 2 while in initial hemodialysis session. Continued to have daily BM...Morphine is a poor choice in ESRD patient, discontinue and use oxycodone as needed instead..."

The facility staff (administrator, DON, and corporate nurses) were made aware of concerns regarding the above in meeting with the survey team on 02/016/17 at approximately 9:30 a.m.

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F 157	Continued From page 6 The DON and corporate nurse stated that no physician's order could be located for the resident to be disimpacted and no information and/or documentation could be located to evidence that the physician was notified of the above. No further information and/or documentation was presented prior to the exit conference on 02/16/17 at 11:45 a.m.	F 157		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident’s status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each	F 278		3/1/17

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F 278	Continued From page 7 assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for one of 22 residents in the survey sample. An annual MDS failed to accurately document Resident #8's fall history that included a fracture. The findings include: Resident #8 was admitted to the facility on 2/22/16 with a re-admission on 12/26/16. Diagnoses for Resident #8 included fractured cervical vertebra, dementia, anxiety, depression and high blood pressure. The MDS dated 1/16/17 assessed Resident#8 with moderately impaired cognitive skills. Resident #8's clinical record documented an annual MDS with an assessment reference date of 1/16/17. Section J1700 for listing the resident's fall/fracture history upon entry or reentry inaccurately listed the resident had no falls in the past month prior to re-admission and no fractures related to a fall in the last 6 months prior to re-admission. Resident #8's clinical record documented the resident was found in the floor of her room on 12/24/16 and was diagnosed	F 278	F 278 1) Resident #8□s MDS dated 1/16/2017 is now accurately coded per recommendation. No untoward outcome related to deficient practice. 2) All readmitted residents are at risk. 3) Staff Development Coordinator or designee will educate all MDS coordinators on accurate coding of sections A0310E and J1700. 4) DON or designee will audit 100% of current residents that have been readmitted within the past 90 days for accuracy in coding A0310E and J1700, then will audit 20% of current residents that have been readmitted for 4 weeks, then quarterly during following QA meeting.	

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with a fractured cervical vertebra. The record documented the resident was re-admitted to the facility following hospitalization for the fractured vertebra on 12/26/16. Further review of the 1/16/17 MDS indicated section A0310E inaccurately indicated this was not the first assessment since the resident was re-admitted.

On 2/15/16 at 10:05 a.m. the registered nurse (RN #1) MDS coordinator was interviewed about Resident #8's fall history listed on the 1/16/17 MDS. After reviewing, RN #1 stated section A0310E should have listed the 1/16/17 MDS as the first assessment since the resident was re-admitted. RN #1 stated if section A0310E had been answered correctly it would have prompted entries for the fall history in section J1700. RN #1 stated the resident's fall and fracture that occurred on 12/24/16 should have been indicated in the fall history section at J1700.

The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on pages A-6 and A-7 states regarding coding instructions for section A0310E, "Code 1, yes: if this assessment is the first of these assessments since the most recent admission/entry or reentry." Page J-27 and J-28 of this reference states concerning completion of section J1700 regarding fall/fracture history, "Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600)...Code 1, yes: if resident or family report or transfer records or medical records document a fall in the 2-6 months prior to the resident's entry date item (A1600)...Code 1, yes: if resident or family report or transfer records or medical records document a fracture related to fall in the

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F 278	Continued From page 9 6 months (0-180 days) preceding the resident's entry date item (A1600)..." (1) These findings were reviewed with the administrator, director of nursing and nurse consultants during a meeting on 2/15/17 at 11:00 a.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, Centers for Medicare & Medicaid Services, Revised October 2016.	F 278		
F 279 SS=E	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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	F 279		3/1/17

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F 279	Continued From page 10 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 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 staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for four of 22 residents	F 279	F 279 1) Residents #5, #7, #8, and #13 care plans are now comprehensive and	

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F 279	Continued From page 11 in the survey sample. Residents #5, #7, #8 and #13 had no individualized care plan developed regarding recreational activities. The findings include: 1. Resident #8 had no comprehensive, individualized care plan regarding recreational activities. Resident #8 was admitted to the facility on 2/22/16 with a re-admission on 12/26/16. Diagnoses for Resident #8 included fractured cervical vertebra, dementia, anxiety, depression and high blood pressure. The minimum data set (MDS) dated 1/16/17 assessed Resident#8 with moderately impaired cognitive skills. Section F0500 of the resident's annual MDS dated 1/16/17 listed groups and participating in favorite activities as the resident's most important activity preferences. Resident #8's care plan (revised 1/18/17) listed the resident was dependent on staff for meeting emotional, intellectual, physical and social needs due to cognitive deficits. The care plan included no individualized problems, goals and/or interventions regarding recreational activities for Resident #8. The care plan goal stated, "The resident will attend/participate in activities of choice 3 - 5 times weekly, to maintain quality her life..." (sic) The only intervention listed to meet this goal was, "Resident will be escorted to and from programs, as needed or requested..." The plan included no reference to any assessed activity preferences or any individualized problems, goals and/or interventions based upon the resident's activity assessments.	F 279	individualized regarding recreational activities. No untoward outcome related to deficient practice. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate Activities Director on creating comprehensive and individualized care plans regarding recreational activities. 4) DON or designee will audit 100% of current residents for accuracy of and individualized care plan regarding recreational activities, then will audit 20% of new admissions for 4 weeks, then quarterly during following QA meeting.	

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On 2/15/17 at 1:45 p.m. the activity director, responsible for recreational care plan development, was interviewed about Resident #8's plan. The activity director stated their company required all residents to have a care plan about activities "so that's what I do." The activity director stated Resident #8 liked "anything involving socializing." The activity director stated Resident #8 liked group activities, music and religious services and needed reminding/queuing to come to many of the events. When asked why the resident's interests and/or preferences were not part of the resident's care plan, the activity director stated she could see where that would be good to include as part of her plan.

These findings were reviewed with the administrator, director of nursing and nurse consultants during a meeting on 2/16/17 at 9:30 a.m.

2. Resident #13 had no comprehensive, individualized care plan regarding recreational activities.

Resident #13 was admitted to the facility on 7/30/16 with diagnoses that included high blood pressure, dementia, chronic kidney disease and bronchitis. The minimum data set (MDS) dated 1/4/17 assessed Resident #13 with severely impaired cognitive skills. Section F0500 of the resident's annual MDS dated 8/5/16 listed pets, keeping up with news and participating in favorite activities as the resident's most important activity preferences.

Resident #13's care plan (revised 1/11/17) listed

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the resident was dependent on staff for meeting emotional, intellectual, physical and social needs due to cognitive deficits. The care plan included no individualized problems, goals and/or interventions regarding recreational activities for Resident #13. The care plan goal stated, "The resident will attend/participate in activities of choice 1 - 3 times weekly, to maintain her quality of life..." The only intervention listed to meet this goal was, "The resident needs assistance/escort to activity functions due to cognitive deficit/short term memory issues, when resident choice to participate or as needed." The plan included no reference to any assessed activity preferences or any individualized problems, goals and/or interventions based upon the resident's activity assessments.

On 2/15/17 at 1:45 p.m. the activity director, responsible for recreational care plan development, was interviewed about Resident #13's plan. The activity director stated their company required all residents to have a care plan about activities "so that's what I do." The activity director stated Resident #13 liked to "stay to herself." The activity director stated Resident #13 liked to re-organize her room, take walks and participate in the exercise program. When asked why the resident's interests and/or preferences were not part of the resident's care plan, the activity director stated she could see where that would be good to include as part of her plan.

These findings were reviewed with the administrator, director of nursing and nurse consultants during a meeting on 2/16/17 at 9:30 a.m.

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3. The facility staff failed to include Resident # 5's preferred activities in the care plan for activities.

Resident # 5 in the survey sample, an 85 year-old female, was admitted to the facility on 8/25/16 with diagnoses that included acidosis, acute kidney failure, chronic duodenal ulcer with hemorrhage, acute hepatic failure, acute post hemorrhagic anemia, dysphagia, and gastroesophageal reflux disease. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/31/16, and the most recent Quarterly MDS, with an ARD of 11/29/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 6 out of 15.

Under Section F (Preferences for Customary Routine and Activities), the resident was assessed at Item F0500 (Interview for Activity Preferences) as indicating it was very important to her to have books, newspapers and magazines to read; to listen to music she likes; to be around animals such as pets; to keep up with the news; to do things with groups of people; to do her favorite activities; to go outside for fresh air in good weather; and, to participate in religious services.

Resident # 5's care plan, dated 8/30/16, included the following problem in the area of Activities, "The resident is dependent on staff for meeting social needs r/t (related to) cognitive deficits." The goal for the problem was, "The resident will attend/participate in activities of choice (1 - 3 times weekly to maintain her social interactions with others) by next review." The intervention for

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the stated problem was, "The resident needs assistance/escort to activity functions."

At 1:50 p.m. on 2/15/17, the Activity Director was interviewed regarding the activities care plan for Resident # 5. Asked what activities Resident # 5 likes, the Activities Director said the resident likes to read and attend group activities. It was then pointed out to the Activities Director that none of the activities preferred by the resident were included as a part of her care plan.

4. The facility staff failed to include all of Resident # 7's preferred activities in the activities care plan.

Resident # 7 in the survey sample, an 85 year-old female, was admitted to the facility on 2/18/16 with diagnoses that included dementia, glaucoma, cerebrovascular disease, legally blind, dysphagia, Vitamin B deficiency, thyrotoxicosis, and depressive disorder. According to the most recent Annual MDS with an ARD of 1/18/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Under Section F (Preferences for Customary Routine and Activities), the resident was assessed at Item F0500 (Interview for Activity Preferences) as indicating it was very important to her to listen to music she likes; to keep up with the news; to do her favorite activities; to go outside for fresh air in good weather; and, to participate in religious services.

Resident # 7's care plan, dated 2/24/16, included the following problem in the area of Activities,

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F 279	Continued From page 16 "Alteration in prior leisure routines." The goal for the problem was, "Attain or maintain the highest practical well being through activities of choice, 1 -3 times weekly, until next review." The intervention for the stated problem was, "Enjoys listening to television, radio, others talking, and group programs (offer assistance as necessary)." The interventions for Resident # 7's activities care plan problem failed to include doing her favorite activities, going outside for fresh air in good weather, and participating in religious services. At 1:50 p.m. on 2/15/17, the failure to include all of Resident # 7's activity preferences was discussed with the Activities Director.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items	F 280		3/1/17

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F 280	Continued From page 17 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 280		

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(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (Comprehensive Care Plan) for a bowel management program for one of 22 residents in the survey sample, Resident # 4.

The facility staff failed to ensure Resident # 4's CCP was reviewed and revised to reflect the resident's individualized bowel assessment and bowel elimination needs.

Findings include:

Resident # 4 was admitted to the facility on 02/19/16. Diagnoses for Resident # 4 included, but were not limited to: anemia, atrial fibrillation, CHF (congestive heart failure), blindness, chronic

F 280
1) Resident #4s comprehensive care plan is now reviewed and revised to include residents individualized bowel elimination needs.
2) All residents with bowel irregularities are at risk.
3) Staff Development Coordinator or designee will educate all licensed staff on completing/updating residents comprehensive care plan to include individualized bowel patterns and interventions for residents with bowel irregularities.
4) DON or designee will audit 100% of Comprehensive care plans for residents with bowel irregularities for individualized accuracy 5x per week for 2 weeks, will

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F 280	Continued From page 19 pain, DM (diabetes mellitus), end stage renal disease on hemodialysis, and constipation. The most recent full MDS (minimum data set) was an annual assessment dated 12/13/16, which assessed the resident as having a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive to total assistance from staff with at least one staff person for physical assistance for all ADL's (activities of daily living), including hygiene and toileting. The resident also triggered in the CAAS (care area assessment summary) area for ADL's, urinary incontinence and indwelling catheter, and for dehydration. A quarterly MDS assessment was reviewed for comparison, dated 09/14/16. This MDS assessed the resident as having short and long term memory impairment with moderate impairment in daily decision making skills. This MDS additionally assessed the resident in section H0400. Bowel Incontinence as a "9", indicating "not rated, resident had an ostomy or did not have a bowel movement for the entire [previous] 7 days." Resident # 4's clinical records were then reviewed to obtain information regarding the resident's past medical history. On 06/10/16 the resident was admitted to the hospital for a left thigh hematoma, a complication of hemodialysis line exchange requiring manual compression. The resident's history on this admission documented that had a history of constipation with stool impaction and recommended an aggressive bowel regimen and	F 280	audit 20% 5x per week for 2 weeks, then quarterly during following QA meeting.	

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F 280	Continued From page 20 disimpaction as needed on the discharge summary. The resident was discharged back to the facility on 06/11/16. The resident's bowel records were reviewed for the month of September 2016 to determine if the resident did in fact, go 7 days without a bowel movement (as documented on the MDS). According to the resident's bowel records, Resident # 4 did not have a BM (bowel movement) from September 8th through September 17th (10 days without a BM). No documentation was found in the nursing notes to evidence that the resident had a BM during this time frame. Further bowel records were reviewed for Resident # 4 and revealed that Resident # 4 had a small BM on 10/24/16 and did not have another BM until 10/31/16 (a 6 day period without a BM). The BM on 10/31/was documented as small, loose, diarrhea. The resident's next BM was documented on 11/04/16 (after a weekly scheduled Fleets enema). A nursing note dated 11/05/16 and timed 12:07 a.m. documented, "At about 9:45 p.m. resident lay in bed with bed elevated to about 30 degree. Had a large amount of undigested food. Stomach rounded and firm c/o [complained of] stomach discomfort. Holding bottom from bed on exam, hard BM @ [at] opening. BM removed, order[ed] [sic] [weekly scheduled enema] fleets given unable to administer more feces removed form [sic] rectum. Fleets given while at [sic] bottom of bed elevated [trendelenburg]. Waited about 5 min [minutes] then sat pt [patient] on shower chair taken to the bathroom. With very large am	F 280		

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[amount] of hard, formed and soft BM results. ABD [abdomen] decreased in round and firmest [sic]. Will continue to monitor..."

The resident's current CCP was reviewed and did not evidence any of the identified problems or history of Resident # 4, as listed above.

The CCP documented, that the resident was 'dependent on staff' for personal hygiene, bathing/showering and toileting. The CCP also documented, to increase fiber and fluids, monitor medications for side effects of constipation, keep physician informed, monitor and document complications related to constipation, and to record bowel movement pattern each day. No other information was found in the resident's CCP regarding constipation and/or bowels. This initial CCP was developed on 02/17/16 (a rolling care plan). The CCP had a revision date of 02/02/17, but did not evidence any updates (none of the information above) and/or any new interventions; only a revision date of 02/02/17.

The resident's clinical record was reviewed and did not evidence that the resident received increased fiber and fluids, or that medications were monitored for side effects of constipation, or that the physician was kept informed of the resident's continued problems with constipation.

The resident's bowel records were reviewed for the month of January 2017. The resident's bowel records documented that the resident had a loose /diarrhea stool on 01/12/17 and another loose/diarrhea stool on 01/15/17 and did not have another BM until 01/22/17 (6 days later) and then did not have another BM until 01/29/17 (another 6 days), which was also documented as large,

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F 280	Continued From page 22 loose/diarrhea. A nursing note dated 01/29/17 and timed 6:13 p.m. documented, that the resident had a large watery and bloody BM at 5:30 p.m. and the physician was notified. The physician ordered to for the resident's vital signs to be rechecked in one hour and to send the resident to the emergency room, if the resident's SBP (systolic blood pressure) was less than 100 or tachycardic (high heart rate), or any further bleeding. The nursing note documented that the resident denied abdominal pain, but complained of hurting all over. A hospital discharge summary was reviewed and documented that the resident was admitted on 01/29/17 at 9:09 p.m. for GI (gastrointestinal bleeding) due to: severe constipation. The resident remained in the hospital until 02/01/17 and was discharged back to the facility. The discharge summary recommended miralax with 32 ounces of water three times daily, dulcolax every other day as needed to ensure at least one BM a day and tap water enema as needed if no BM (formed and adequate quantity) for 3 days. The discharge summary further documented, that the resident may have liquid BM around a stool ball so please don't hold miralax for small amount of loose stool. None of the above information was found on the resident's CCP. The survey team met with the DON (Director of Nursing), the administrator and the corporate nurses on 02/16/17 at approximately 9:30 a.m. The corporate nurse stated that the facility had failed in the resident's care plan and further	F 280		

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F 280	Continued From page 23 stated that the care plan was not updated. No further information or documentation was presented prior to the exit conference on 02/16/17 at 11:45 a.m.	F 280		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309		3/1/17

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residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain a physician's order prior to disimpacting a resident, and failed to ensure appropriate monitoring and implementation of interventions of a bowel management program for one of 22 residents in the survey sample, Resident # 4.

The facility staff failed to obtain a physician's order prior to disimpacting Resident # 4 and repeatedly failed to implement interventions of a bowel regimen/protocol for the resident that was identified as having chronic constipation.

Findings include:

Resident # 4 was admitted to the facility on 02/19/16. Diagnoses for Resident # 4 included, but were not limited to: anemia, atrial fibrillation, CHF (congestive heart failure), blindness, chronic pain, DM (diabetes mellitus), end stage renal disease on hemodialysis, and constipation.

The most recent full MDS (minimum data set) was an annual assessment dated 12/13/16, which assessed the resident as having a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive to total assistance from staff with at

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1) Resident #4 has had no further episodes requiring disimpaction or digital stimulation. Bowel regimen implemented and resident #4 is having bowel movements in concurrence with individualized plan of care.
2) All residents with acute or chronic constipation are at risk.
3) Staff Development Coordinator or designee will educate all Licensed Staff on:
a. Obtaining a physician order prior to initiating disimpaction procedures.
b. Procedures to monitor for constipation and when/how to implement interventions of a bowel management program.
4) DON or designee will audit 100% of residents at risk for constipation for appropriate implementation of interventions and/or obtaining a physician□s order for disimpaction 5x per week for 2 week, then will audit 20% 5x per week for 2 weeks, then quarterly in following QA meeting.

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F 309	Continued From page 25 least one staff person for physical assistance for all ADL's (activities of daily living), including hygiene and toileting. The resident also triggered in the CAAS (care area assessment summary) area for ADL's, urinary incontinence and indwelling catheter, and for dehydration (dehydration was not checked to care plan). A quarterly MDS assessment was reviewed for comparison, dated 09/14/16. This MDS assessed the resident as having short and long term memory impairment with moderate impairment in daily decision making skills. This MDS additionally assessed the resident in section H0400. Bowel Incontinence as a "9", indicating "not rated, resident had an ostomy or did not have a bowel movement for the entire [previous] 7 days." Resident # 4's clinical records were then reviewed to obtain information regarding the resident's past medical history. A hospital discharge form dated 06/11/16 documented, "...R [right] sided abdominal mass c/w [consistent with] chronic stool impaction seen on previous imaging from 2012. Recommend aggressive bowel regimen and disimpacting as needed..." The resident's bowel records were reviewed for the month of September 2016 to determine if the resident did in fact, go 7 days without a bowel movement. According to the resident's bowel records, Resident # 4 did not have a BM (bowel movement) from September 8th through September 17th (10 days without a BM). No	F 309		

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documentation was found in the nursing notes to evidence that the resident had a BM during this time frame.

Resident # 4's MARs (medication administration records) were then reviewed for the month of September 2016 and documented that the resident received the following scheduled medications daily, senna 8.6 mg (milligrams) two tablets at bedtime, lactulose 20 grams twice daily, and a fleets oil enema every 7 days (Friday).

The resident additionally had PRN (as needed) medications for bowel management, which included: a Bisacodyl suppository 10 mg every 6 hours as needed for bowel supplement, milk of magnesia 2000 mg every 24 hours as needed for constipation daily, and a mineral oil enema 4 ounces every 12 hours as needed.

According to the clinical record, none of the above PRN medications for bowel supplementation was administered to Resident # 4. Additionally, no information or documentation could be located within the clinical record to evidence that the physician was made aware that Resident # 4 had not had a bowel movement in 10 days.

Further bowel records were reviewed for Resident # 4 and revealed that Resident # 4 had a small BM on 10/24/16 and did not have another BM until 10/31/16 (a 6 day period without a BM). The BM on 10/31/16 was documented as small, loose, diarrhea. The resident's next BM was documented on 11/04/16 (after the weekly scheduled Fleets enema).

Again, the resident did not receive any PRN

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medications for bowel supplementation.

A nursing note dated 11/05/16 and timed 12:07 a.m. documented, "At about 9:45 p.m. resident lay in bed with bed elevated to about 30 degree. Had a large amount of undigested food. Stomach rounded and firm c/o [complained of] stomach discomfort. Holding bottom from bed on exam hard BM @ [at] opening. BM removed order[ed] [sic] fleets [scheduled enema] given unable to administer more feces removed form [sic] rectum. Fleets given while at [sic] bottom of bed elevated [trendelenburg]. Waited about 5 min [minutes] then sat pt [patient] on shower chair taken to the bathroom. With very large am [amount] of hard, formed and soft BM results. ABD [abdomen] decreased in round and firmest [sic]. Will continue to monitor..."

Resident # 4 physician's orders were again reviewed and did not evidence that a physician's order had been obtained prior to disimpaction/digitally removing stool from the resident's rectum. The resident again did not receive any of the physician ordered, PRN medications to facilitate the resident in having a bowel movement.

A nursing note dated 11/05/16 and timed 1:04 p.m. documented, "....dialysis center reporting that pts BP [blood pressure] 221/112- temp 100.8 transported via EMS [emergency medical service]..."

The resident's hospital discharge summary documented the resident was admitted to the hospital on 11/05/16 and discharged on 11/08/16. The discharge summary documented, "...leukocytosis, abdominal pain, Acute on chronic

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F 309	Continued From page 28 constipation...per the SNF [skilled nursing facility] nurse, report from sign out was that he [resident] was very constipated and required aggressive disimpaction this morning...blood pressure was noted to be elevated at the SNF with a temperature of 100.2...exam notable for SBP [systolic blood pressure] 170-220, tachycardia, abdominal distention and tenderness...leukocytosis mild on presentation. Only abdominal pain positive on exam...resolved with treatment of constipation...Abdominal pain with history of chronic constipation: Disimpaction at SNF prior to admission, Had BM times 2 while in initial hemodialysis session. Continued to have daily BM...Morphine is a poor choice in ESRD patient, discontinue and use oxycodone as needed instead..." A physician's progress note dated 11/10/16 documented, "....CAD, CHF, DM, ESRD on HD...from dialysis with fever...new dialysis catheter placed, new BP meds started...abd...stable with edema..." This physician's progress note did not address or mention the resident's history of constipation and did not address or mention the resident being disimpacted or any information related to the resident's bowels. Resident # 4's CCP (comprehensive care plan) was reviewed. The CCP documented, "...created on 02/29/16...ADL self care performance deficit...personal hygiene...resident is dependent on staff...toilet use...resident is dependent on staff...anticipate and meets needs created on 02/17/16...The resident has constipation related to decreased mobility, use/side effects of medication...created on 02/17/16...The resident will have a normal bowel movement at least every	F 309		

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F 309	Continued From page 29 3rd day...increase fiber and fluid intake to provide more bulk in diet, monitor medications for side effects of constipation. Keep physician informed of any problems, Monitor/document/report PRN s/sx [signs and symptoms] of complications related to constipation, Record bowel movement pattern each day. Describe amount, color, and consistency..." The resident's bowel records were reviewed for the month of January 2017. The resident's bowel records documented that the resident had a loose /diarrhea stool on 01/12/17 and another loose/diarrhea stool on 01/15/17 and did not have another BM until 01/22/17 (a total of 6 days) and then did not have another BM until 01/29/17 (another 6 days), which was also documented as large, loose/diarrhea. A nursing note dated 01/29/17 and timed 6:13 p.m. documented, that the resident had a large watery and bloody BM at 5:30 p.m. and the physician was notified. The physician ordered for the resident's vital signs to be rechecked in one hour and to send the resident to the emergency room, if the resident's SBP (systolic blood pressure) was less than 100 or tachycardic (high heart rate), or any further bleeding. The nursing note documented that the resident denied abdominal pain, but complained of hurting all over. A hospital discharge summary was reviewed and documented that the resident was admitted on 01/29/17 at 9:09 p.m. for GI (gastrointestinal bleeding) due to: severe constipation. The resident remained in the hospital until 02/01/17 and was discharged back to the facility. The discharge summary recommended miralax with	F 309		

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32 ounces of water three times daily, dulcolax every other day as needed to ensure at least one BM a day and tap water enema as needed if no BM (formed and adequate quantity) for 3 days. The discharge summary further documented, that the resident may have liquid BM around a stool ball so please don't hold miralax for small amount of loose stool.

There was no evidence that the physician had been notified of the above information, until the resident began having bloody stool on 01/29/17. None of the above information was found on the resident's CCP, and no new interventions were added to the resident's CCP. The resident's MARs were reviewed and the resident did not receive any of the physician ordered PRN medications for constipation to assist the resident in having regular or more frequent bowel movements.

A physician's progress note was reviewed dated 02/03/17, which documented, "...bloody BM noted...Severe constipation noted...abd notable with distention with edema...constipation...med ordered..."

On 02/15/17 at approximately 11:00 a.m., the DON (director of nursing), the administrator and nurse consultants were made aware of concerns regarding Resident # 4 in a meeting with the survey team. The facility staff were made aware of concerns regarding the resident's bowel regimen, with lack of physician notification and the non use of any physician ordered PRN medications for the promotion of bowel movements for Resident # 4. Facility policies and/or protocols were requested for bowel protocol and disimpaction.

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The facility policies were presented and reviewed. A policy titled, "Constipation Prevention" documented, "Patients will be monitored for regular bowel elimination...a bowel movement every three days or as determined by individual assessment...nurse will routinely review to determine...need of intervention to facilitate bowel movement...elevation in temperature... malaise... drowsiness... frequent bouts of diarrhea... nausea and/or vomiting... initiate any or all of the following interventions as needed: prune juice followed by a glass of warm water... high fiber foods with adequate fluids... natural laxative... stool softeners, suppositories, laxatives, and/or enemas as ordered by the physician... contact physician for any needed orders... the plan for prevention of constipation will be documented on the comprehensive care plan."

On 02/15/16 at approximately 2:30 p.m., the resident's individual 'bowel' assessment was requested.

On 02/15/16 at approximately 3:50 p.m., the UM (Unit Manger) for Resident # 4 presented two sheets of paper and stated that these are Resident # 4's bowel assessments. The two documents were reviewed. The documents were titled, "Elimination Data Collection for Trial Bowel & Urinary Toileting Program." One was dated 11/09/16 (a 7 day log) and the other was dated 02/06/17. The Unit manager was asked if this was all she had, the UM stated, yes. The forms presented documented if the resident was dry, wet, or had a bowel movement, these were forms to determine if the resident was a candidate for a toileting program; this was not a bowel assessment.

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At approximately 4:15 p.m., the corporate nurse stated that they (staff) did not find an individual bowel assessment for Resident # 4.

A facility policy titled, "Digital Rectal Stimulation" was reviewed. The policy documented, "...will be performed by a licensed nurse with a specific physician's order... check blood pressure and pulse before and after procedure... collaborate with the patient to identify stimulus to facilitate an appropriate bowel routine..."

A facility policy titled, "Manual Evacuation of Stool from the Bowel" documented, "Manual removal of stool will be performed by a licensed nurse with a specific physicians' order...obtain baseline pulse and blood pressure... patient in a left side-lying position with right knee slightly flexed... gently remove stool..."

On 02/16/17 at approximately 9:30 a.m., the survey team had a meeting with the administrator, the DON (director of nursing), and the corporate nurses. The facility staff were made aware of the concerns regarding Resident # 4.

The DON stated that he (Resident # 4) was a special case and with him, the bowel regimen identified from the bowel and bladder elimination every 7 days (for bowel movements), he should have a bowel movement every 7 days. The DON was made aware that the forms that were presented as the resident's bowel assessment were not an actual assessment and that only two were presented, one from November 2016 (1 week) and one for February 2017 (1 week).

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F 309	Continued From page 33 The corporate nurse stated that the 'protocol' doesn't apply to him (Resident # 4) and went on to say that typical for him is 7 days. The facility staff were made aware that the resident went more than 7 and was never administered any of the PRN medications to facilitate a bowel movement and that the resident's CCP did not have any information documenting that the resident only went every 7 days. The corporate nurse stated in regards to no PRN bowel medications being administered, that "they should have been." The facility staff stated that ultimately it is the nurse's (medication/charge nurse) responsibility to monitor bowel movements for residents and we (facility) failed to care plan and the PRN medications should have been administered. No further information and/or documentation was presented prior to the exit conference on 02/16/17 11:45 a.m.	F 309		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (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 371		3/1/17

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F 371	Continued From page 34 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to prepare and served food in a sanitary manner on two of four unit kitchens. 1) A dietary employee failed to follow proper hand washing technique during lunch service on the 200 unit. 2) A dietary employee put her hands directly into stored ice in the 400 unit kitchen. The findings include: 1. A dietary employee failed to follow proper hand washing technique during lunch service from the 200 unit kitchen. After washing his hands, dietary employee #1 directly touched the faucet handles prior to drying his hands with a paper towel. Lunch service from the 200 unit kitchen was observed on 2/14/17 from 12:05 p.m. until 12:40 p.m. Dietary employees were observed during this time preparing food items, setting up cooked foods in the steam table and assembling service utensils, glassware and plates. On 2/14/17 at 12:25 p.m. dietary employee #1 was observed	F 371	F 371 1) All dietary employees involved were immediately educated on proper handwashing and ice handling procedures. No untoward outcome related to deficient practice. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all dietary staff on the following: a. Proper handwashing techniques. b. Safe and sanitary techniques for handling ice. 4) DON or Designee will audit each kitchen□s service of one meal 5x per week for 1 week for: a. Appropriate handwashing techniques b. Safe and sanitary techniques for handling ice Then 2 kitchen□s service of one meal 3x per week for 3 weeks, then quarterly in the following QA meeting.	

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washing his hands. Dietary employee #1 wet his hands, applied soap, scrubbed his hands, rinsed and then turned off the water by directly touching the faucet handles. Dietary employee #1 then dried his hands with a paper towel. Dietary employee #1 was observed again on 2/14/17 at 12:35 p.m. washing his hands in the same manner.

The facility's policy for hand washing posted at each kitchen sink documented steps for proper hand washing as follows, "Wet your hands with running water... Apply soap... Vigorously scrub hands and arms for at least 10 to 15 seconds... Rinse hands and arms thoroughly... Dry hands and arms with a single-use paper towel...Use a paper towel to turn off the faucet..."

On 2/15/17 at 8:55 a.m. the dietary manager was interviewed about the hand washing observed during lunch service from the unit 200 kitchen. The dietary manager stated the employee should have dried his hands with a paper towel prior to turning off the water. The dietary manager stated employees were to use a paper towel when touching the faucet handles after washing their hands. The dietary manager stated the proper hand washing steps were posted at each kitchen sink for reference.

These findings were reviewed with the administrator, director of nursing and nursing consultants during a meeting on 2/16/17 at 9:30 a.m.

2. The facility staff failed to ensure safe and

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sanitary handling of ice.

Findings include:

On 02/14/17 at 12:05 p.m., the sub kitchen located (small kitchenette located on each unit) on the 400 hall was observed.

A DA (Dietary Aide) came into the sub kitchen. The DA spoke to a staff member that was waiting in the hall and stated, "I'll get it for you." The DA had a cup in her hand and went to the ice bin. The DA opened the ice bin lid, where the ice scoop was submerged in the ice. The DA moved the ice away from the scoop with her bare hand and then picked up the scoop, scooped up some ice and put it into the cup, put the ice scoop in the actual scoop holder, shut the ice bin lid and gave the cup of ice to the staff member in the hall. The DA did not have gloves on and did not wash her hands prior to or after obtaining the ice.

The DA was asked if she realized what she had just done. The DA stated, I didn't wash my hands." The DA was asked if there was anything else. The DA stated, "I didn't wash my hands." The DA was made aware that she did not wash her hands, that she had touched the ice-moving it away from the ice scoop and then picked up the ice scoop that was submerged in the ice. The DA was asked what should be done now. The DA stated, "Wash my hands" and went to the sink and began washing her hands. The DA was asked where the ice scoop should go, the DA stated that the ice scoop has a holder and pointed it out. The DA did not know who left the ice scoop down in the ice.

At approximately 12:15 p.m., the dietary director

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F 371	Continued From page 37 and the RD (Registered Dietitian) entered the sub kitchen and were made aware of the above observation. A policy was requested at this time on sanitary handling of ice/ice machines/ice scoops. At approximately 2:30 p.m. a policy was presented and reviewed. The policy titled, "Patient Care Equipment" documented, "...Ice Machines/Portable Ice Chest, Hydration Carts a. All ice handlers should be taught the following precautions: b. Perform hand hygiene frequently. c. Hold scoop by handle (do not touch bowl surface or inside of the ice chest with hands). d. Do not handle ice with hands..." The administrator, DON (director of nursing) and the corporate nurses were made aware in a meeting with the survey team on 02/15/17 at approximately 11:00 a.m. No further information or documentation was presented prior to the exit conference on 02/16/17 at 11:45 a.m.	F 371		