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| ASHLAND NURSING AND REHABILITATION | 906 THOMPSON STREET ASHLAND, VA 23005 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 1/10/18 through 1/11/18 and 1/16/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint(s) was investigated during the survey. | E 000 | Preparation and /or execution of this plan does not constitute admission or agreement with the provider of truth of the facts alleged or conclusion set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. | |
| E 035 SS=F | LTC and ICF/IID Sharing Plan with Patients<br>CFR(s): 483.73(c)(8)<br><br>[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:<br><br>(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility document review it was determined, the facility staff failed to have a complete emergency preparedness plan.<br><br>The facility staff failed to provide evidence of documentation that the communication plan included a method for sharing information from the emergency plan, that the facility had determined is appropriate, with residents or clients and their families or representatives.<br><br>The findings include:<br><br>On 1/11/18 at approximately 11.00 a.m. a review of the facility's emergency preparedness plan was | E 035 | **E 035**<br><br>1. Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives per regulation 1/22/2018.<br><br>2. Quality review of Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives per regulation completed by the Executive Director (ED)/ designee. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ERmce — TITLE: Executive Director — (X6) DATE: 2/12/18

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

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| E 035 | Continued From page 1<br>conducted. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan included a method for sharing information from the emergency plan, that the facility had determined is appropriate with residents or clients and their families or representatives.<br><br>On 1/11/18 at 5:35 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 was asked to provide evidence that facility residents, family members and / or responsible parties had been provided the information regarding the facility emergency preparedness plan.<br><br>On 1/16/18 at 12:20 p.m. ASM #1 stated that she did not provide any training to the residents, family members and / or responsible parties. ASM #1 further stated, "I need to work on this (the facility emergency preparedness plan) a little more."<br><br>No further information was obtained prior to the end of the survey process. | E 035 | 3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives is completed annually per regulation.<br><br>4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives is completed annually per regulation weekly x 2 weeks, monthly x 2 months, then | |
| E 036 SS=F | EP Training and Testing<br>CFR(s): 483.73(d)<br><br>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must | E 036 | | |

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| E 036 | Continued From page 2<br>be reviewed and updated at least annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).<br><br>*[For ESRD Facilities at §494 62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan.<br><br>The facility staff failed to provide evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing | E 036 | quarterly and PRN and indicated.<br>Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.<br><br>5. Date of Compliance: 3-2-18 | |

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| E 036 | Continued From page 3<br>program has been initiated for all staff in the facility.<br><br>The findings include:<br><br>On 1/11/18 at approximately 11:00 a.m. a review of the facility's emergency preparedness plan was conducted. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that training and testing had been conducted for the facility emergency plan.<br><br>On 1/11/18 at 5:35 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 was asked to provide evidence that training and testing had been conducted by the facility for the emergency preparedness plan.<br><br>1/16/18 at 12:20 p.m. ASM #1 stated that training and testing had not been conducted. ASM #1 further stated that she did not have a policy regarding the emergency preparedness plan.<br><br>No further information was obtained prior to the end of the survey process. | E 036 | **E036:**<br><br>1. Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with facility staff annually per regulation 1/23/18.<br><br>2. Quality review of Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with facility staff annually per regulation completed by the Executive Director (ED)/ designee.<br><br>3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with facility staff is completed annually per regulation. | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated complaint survey was conducted 1/10/18 through 1/11/18 and 1/16/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Quality of Care at F 689 at a Scope and Severity of pattern, level 4, and which constituted Substandard Quality of Care. A second | F 000 | | |

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| F 000 | Continued From page 4<br>immediate jeopardy was identified in the area of Nursing Services at F 729 at a Scope and Severity of pattern, level 4.<br><br>The census in this 190 certified bed facility was 165 at the time of the survey. The standard survey sample consisted of 5 current resident reviews (Residents #2 through #5) and 1 closed record reviews (Resident #1). The expanded survey sample consisted of the 5 current resident reviews (Residents #2 through #5).<br><br>At the end of the findings:<br><br>After accepting the plan for removal of the first Immediate Jeopardy in the area Quality of Care F 689 from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of isolated, level 3 pattern. After accepting the plan for removal of the second Immediate Jeopardy in the area of Nursing Services F 729 from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity of widespread, level 2. | F 000 | 4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan ensuring Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with facility staff is completed annually<br><br>per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated.<br>Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |
| F 606 SS=E | Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4)<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(3) Not employ or otherwise engage individuals who-<br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, | F 606 | 5. Date of Compliance: 3-2-18 | |

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| F 606 | Continued From page 5 | F 606 | | |

exploitation, mistreatment of residents or misappropriation of their property; or
(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined the facility staff failed to screen CNA (certified nursing assistants) for abuse by failing to verify certifications upon hire for seventeen out of 79 currently employed CNAs (certified nursing assistant), (CNA #3, CNA #5, CNA #7 and CNA #19 through 32); and certification expiration, and by failing to run criminal background checks within thirty days of hire.

1. The facility staff failed to obtain certification verification for seventeen out of 79 currently employed CNAs (certified nursing assistant). Seventeen out of the 79 currently employed CNAs had expired certifications in their employee file. The CNAs included CNA #3, CNA #5, CNA #7 and CNA #19 through 32.

2. The facility staff failed to obtain certification verifications prior to hire for three of 79 currently employed CNAs, CNA #3, CNA #10 and CNA #11. All three CNAs were found to have a pending violation against their certification and

**F606:**

1. Identified Certified Nursing Assistant (C.N.A)'s certification verification obtained and placed in the employee file 1/11/18. Identified CNAs pending violation documents obtained, validated/addressed and placed in the employee file 1/11/18. Identified C.N.A's criminal background checks/Virginia State Police obtained and placed in the employee file 1/11/18.

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| F 606 | Continued From page 6 | F 606 | | |

were providing direct care to residents.

3. The facility staff failed to obtain criminal background checks from the Virginia State Police within thirty days of hire for two of 79 currently employed, CNA #3 and CNA #10.

The findings include:

1. On 1/10/18 at 1:15 p.m., surveyors entered the facility to investigate a two-day complaint. During the course of investigation, an immediate jeopardy was identified and a substandard review and expanded survey was initiated.

Part of the substandard review is to ensure all currently employed CNAs (certified nursing assistants) have registry verification of their certifications. A list of currently employed CNAs was requested on 1/10/18 at approximately 5:30 p.m. with their employee file.

On 1/11/18 at approximately 9:00 a.m., review of the CNA employee files was conducted. Less than 50 percent of the 79 currently employed CNAs had an up-to-date certification in their employee file.

On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the human resources director. When asked who was responsible for verifying certifications, OSM #2 stated she verified certifications. When asked about the process followed for verifying certifications, OSM #2 stated when a future employee fills out an application, she will decide from the application if they are a good fit for the company. She will then have the applicant come

2. A quality review of current CNA employee files by the Human Resources Coordinator (HRC) completed to ensure CNA certification verification is current, pending violation documents obtained and addressed as applicable and validated by Executive Director (ED)/Director of Nursing Services (DON) with documentation in the employee file per regulation. CNA's without a current certification and/or pending violations to be removed from the schedule until certification and/or pending violation documents obtained and validated by the ED/DON with documentation in the employee file per regulation prior to accepting an assignment.

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into the facility to introduce them to the DON (Director of Nursing). OSM #2 stated she will then run a background check and if the background check comes out clean, she will run their certification. When asked if there were any other times, she would verify certifications, OSM #2 stated she has a computer system (payroll program) that alerts her when an employee's certification needs to be verified. When asked why certifications need to be verified, OSM #2 stated certifications need to be verified to ensure that certifications are not expired and to ensure there are no violations against the certification. When asked where certifications should be filed, OSM #2 stated certifications should be filed in the employee's file. OSM #2 stated she would try to find additional certifications.

On 1/11/18 at approximately 3:00 p m., OSM #2 handed this writer a stack of certifications that were verified on 9/10/17. OSM #2 stated she had realized that some CNAs had expired certifications in their employee file and she had printed out current certifications from the department of health professions website. OSM #2 stated if a current certification was not in the employee file or in the stack of paper just given to this writer, then she did not have them.

On 1/11/18 at approximately 3:00 p.m., review of the stack of CNA certifications was conducted. Seventeen out of the 79 currently employed CNAs did not have their certification verified. Seventeen out of the 79 current CNAs had expired certifications in their employee file. The CNAs included CNA #3, CNA #5, CNA #7 and CNA #19 through 32. Review of the as-worked schedule from the past two weeks prior to entrance, revealed that the 17 CNAs identified

A quality review of current CNA employee files by the HRC completed to ensure criminal background checks/Virginia State Police is current, and validated by ED/DON with documentation in the employee file within 30 days of hire. CNAs without a current criminal background check to be removed from the schedule until a background check is obtained, and validated by the ED/DON with documentation in the employee file prior to accepting an assignment

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| F 606 | Continued From page 8<br>had been directly working with residents and providing care.<br><br>On 1/11/18 at 4:00 p.m., facility staff presented current certification verifications of the identified 17 CNAs. The certifications were printed from the DHP (Department of Health Professions) website on 1/11/18. All identified CNA's had a current certification.<br><br>On 1/11/18 at 4:44 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated the human resources director was responsible for verifying certifications. When asked why certifications should be verified, ASM #1 stated certifications should be verified to ensure a certification is current and in good standing. ASM #1 stated certifications should be checked before her interview with the applicant. ASM #1 stated she cannot interview the applicant without the employee file and a copy of their current certification. ASM #1 stated all CNAs should have a current certification in their employee file.<br><br>On 1/11/18 at 4:44 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.<br><br>2. The facility staff failed to obtain certification verifications prior to hire for three of 79 currently employed CNAs, CNA #3, CNA #10 and CNA #11. All three CNAs were found to have a pending violation against their certification that had not been investigated by administration. All three CNAs had directly worked with residents by | F 606 | 3. HRC re-educated by the ED/DON/designee regarding ensuring CNA certification verification is current, pending violation documents reviewed/addressed as applicable and validated by the ED/DON per regulation prior to accepting an assignment ensuring CNAs are screened for Abuse.<br>HRC re-educated by the ED/DON/designee regarding new CNA applicant's certification verification to be reviewed, pending violation documents reviewed/addressed as applicable and validated by the ED/DON per regulation upon hire and prior to extending an offer of employment to ensure applicants are screened for abuse.<br>HRC re-educated by the ED/DON/designee regarding ensuring criminal background checks/Virginia State Police is obtained, placed in the employee file and validated by ED/DON within 30 days of hire to ensure employees are screened for abuse.<br>HRC re-educated by the ED/DON/Designee regarding | |

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| F 606 | Continued From page 9<br>providing care.<br><br>On 1/11/18 at approximately 9:00 a.m., review of CNA #3's employee file was conducted. CNA #3 did not have a current certification in her employee file. CNA #3's hire date was 9/19/17.<br><br>On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the human resources director. When asked who was responsible for verifying certifications, OSM #2 stated she verified certifications. When asked about the process followed for verifying certifications, OSM #2 stated when a future employee fills out an application, she will decide from the application if they are a good fit for the company. She will then have the applicant come into the facility to introduce them to the DON (Director of Nursing). OSM #2 stated she will then run a background check and if the background check comes out clean, she will run their certification. When asked why certifications need to be verified, OSM #2 stated certifications need to be verified to ensure certifications are not expired and to ensure there are no violations against the certification. When asked where certifications should be filed, OSM #2 stated certifications should be filed in the employee's file.<br><br>On 1/11/18 at approximately 3:00 p.m., OSM #2 handed this writer a stack of certifications that were verified on 9/9/17 through 9/10/17. OSM #2 stated she had realized some CNAs had expired certifications in their employee file and she had printed out current certifications from the department of health professions website. CNA #3's current certification could not be found in the stack of certifications. OSM #2 stated if a current | F 606 | CNAs whose certification is due to expire within the month are to be provided a letter requiring signature communicating certification renewal due date with documentation in the employee file. CNA's without proof of current certification to be removed form the schedule until proof of current certification is provided and validated by the ED/DON with documentation in the employee file.<br>ED/DON to be provided a list monthly with identified CNAs.<br>Human Resources re-educated by the ED/DON/designee regarding responsibility for maintaining the appropriate documentation in the CNA employee file and providing a copy of the Quality Monitor monthly to the DON and ED. | |

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certification was not in the employee file or in the stack of paper just given to this writer, then she did not have them.

On 1/11/18 at 4:00 p.m., facility staff presented the current certification verification for CNA #3. The certification verification was printed from the Department of Health Professions Website on 1/11/2018. CNA #3 had a pending violation against her certification that had not been resolved by the Board of Nursing. The following was documented on CNA #3's certification: "Additional public information: YES..."YES" means that there is information the Department of Health must make available to the public pursuant to 54.1-2400. G The Code of Virginia; please note that this may also include proceedings in which a finding of "no violation was made."

On 1/11/18 at 4:20 p.m., further interview was conducted with OSM #1. OSM #1 was asked about the process followed if she were to verify a CNA's certification and found a "YES" on their certification indicating that there may be a pending violation against their certification. OSM #1 stated she would not know what to do at that time. OSM #1 stated she would go to the DON about the certification. OSM #1 stated the pending violation may also need to be investigated by the administrator. OSM #1 could not recall a time when a CNA had a pending violation against their certification.

On 1/11/18 at 4:23 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON. The DON was asked about her involvement in the hiring and

4. HRC/Designee to conduct random quality monitoring of C.N.A employee files to ensure certification verification is current, located in the employee and validated by the ED/DON upon hire to ensure employees are screened for abuse per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.
HRC/Designee to conduct random quality monitoring of C.N.A employee files to ensure new CNA applicant's certification verification reviewed and validated by the ED/DON upon hire and prior to extending an offer of employment to ensure employees are screened for abuse per regulation weekly x 4 weeks, twice monthly x 4

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certification verification process. ASM #2 stated after the application was reviewed by human resources, she would have the applicant come in for an interview and introduce the applicant to the administrator. ASM #2 stated if they liked the applicant, they would run a background check. If the background check was clean, then human resources would verify the certification. ASM #2 stated the administrator would make the final decision to hire an applicant. ASM #2 was not aware of a time where they hired an applicant with a pending violation against their certification. ASM #2 could not recall verifying CNA #3's certification. ASM #2 stated if a CNA had a pending violation, it would be the administrator's decision whether the applicant was hired.

On 1/11/18 at 4:44 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated the human resources director was responsible for verifying certifications. When asked why certifications should be verified, ASM #1 stated certifications should be verified to ensure a certification is current and in good-standing. ASM #1 stated certifications should be checked before her interview with the applicant. ASM #1 stated she cannot interview the applicant without the employee file and a copy of their current certification. ASM #1 stated all CNAs should have a current certification in their employee file. When asked about the process followed if a CNA had a pending violation against their certification, ASM #1 stated her decision to hire an applicant would depend on the violation. ASM #1 stated if the violation were still pending, she would not hire that person until she found additional information from the Board of Nursing. When asked if she had recently hired a CNA that had a pending violation against their certification,

weeks, then monthly, PRN and as indicated.
HRC/Designee to conduct random quality monitoring of C.N.A employee files to ensure criminal background checks/Virginia State Police is obtained, placed in the employee file and validated by ED/DON within 30 days of hire per regulation to ensure employees are screened for abuse 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.
HRC/designee to conduct random quality monitoring regarding CNAs whose certification is due for renewal within the month are to be provided a letter requiring signature communicating certification renewal due date with documentation in the

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ASM #1 stated, "No, not recently. Not at this job at all." When asked what she could recall about hiring CNA #3, ASM #1 stated she was not aware that CNA #3 had a pending violation against her certification. ASM #1 stated that CNA #3 will be suspended until she receives additional information regarding her pending violation from the Board of Nursing.

On 1/11/18 at 5:25 p.m., the Administrator and DON (Director of Nursing) were able to evidence they had suspended CNA #3 until further investigation. The Administrator and DON were able to evidence they removed this CNA from the working schedule dated 1/11/18 through 1/16/18.

On 1/16/18 at 9:30 a.m., further interview was conducted with ASM #2, the DON. When asked what CNA #3's violation was on her certification, ASM #2 stated her pending violation was from 2013 and no violation was found. ASM #2 stated the board of nursing had not yet taken the pending violation off the website. ASM #2 stated she could not obtain additional information regarding the violation. ASM #2 stated she had also found two additional CNAs who had pending violations on their certification but they were clear to work. ASM #2 was asked to provide evidence that these CNAs had no violations on their certification. ASM #2 stated she would try to get in touch with the department of health professions.

Review of CNA #3's time card revealed that she had worked approximately 70 shifts as a CNA providing direct patient care from 10/05/17 until 1/11/18 (when CNA #3 was suspended). Further review of the time card revealed CNA #3 was removed from the schedule on 1/11/18 and

employee file to ensure employees are screened for Abuse per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.
HRC/designee to conduct random quality monitoring of employee files regarding CNA's without proof of current certification to be removed form the schedule until proof of current certification is provided and validated by the ED/DON with documentation in the employee file to ensure employees are screened for abuse per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance: 3-2-18

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remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #3, documented the following: "Employee was suspended via telephone secondary to violation of level 2 -#30. Employee was told that she cannot clock in or return to work until the investigation is complete. Employee verbalized understanding and stated she had a letter to bring in from the board."

The facility had identified two additional CNAs, CNA #10 and CNA #11 who had pending violations on their certifications.

1. CNA #10 was hired on 6/6/17 and her certification was not verified until 9/10/17. Review of her time card revealed she had worked approximately 73 shifts as a CNA providing direct patient care from 9/21/17 until 1/12/18 (when CNA #10 was suspended). Further review of the time card revealed CNA #10 was removed from the schedule on 1/12/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #10, documented the following: "Employee was suspended secondary to level 2 -#30. Employee was informed that she is suspended pending investigation. Employee stated she has a letter at home clearing her. Employee was informed to bring in. Employee comments: I went to the board of nursing for verbal abuse and they cleared it and said I wasn't guilty and cleared me from the verbal abuse and nothing was on my certification."

2. CNA #11 was hired on 2/2/15 and her certification was not verified until 9/9/17. Review of her timecard revealed that she had worked approximately 83 shifts as a CNA providing direct

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patient care from 9/27/17 until 1/12/18 (when she was removed from the schedule). Further review of the time card revealed that CNA #10 was removed from the schedule on 1/12/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #11, documented the following: "Employee was suspended secondary to level 2 -#30. Employee was informed that she is suspended pending investigation. Employee stated she has a letter at home clearing her. Employee was informed to bring it in. Employee comments: I went to the state boards for having to put a woman down on the floor from a sit to stand because I went to put the other strap on and the chair moved. And I never had used a sit to stand before and I was told I could hook them up by myself and then go get someone to transfer."

On 1/16/18 at 11:10 a.m., an interview was conducted with OSM (other staff member) #6, the Discipline Specialist for the Virginia Board of Nursing. OSM #6 stated that CNA #3, CNA #10, and CNA #11 had no violation pending on their certification. OSM #6 stated when a certified professional has a pending violation on their certification, an informal conference with the certified professional and board of nursing will occur. OSM #6 stated that is when the board of nursing will review the case and decided whether the certified professional is guilty of a violation or cleared. OSM #6 stated that all CNAs should have received a letter from the board stating that no violation was found. OSM #6 stated it takes a while for this information to come off the website. When asked the reason for each CNA to be presented to the board, OSM #6 stated, "That is not public information." OSM #6 could not give any information of when each CNA was cleared

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from their pending violation.

On 1/16/18 at 2:00 p.m., ASM #1, the administrator and ASM #2, the DON were made aware of the above findings.

3. The facility staff failed to obtain criminal background checks from the Virginia State Police within thirty days of hire for two of 79 currently employed, CNA #3 and CNA #10.

On 1/11/18 at approximately 10:30 a.m., review of CNA #3's employee file was conducted. CNA #3 was hired on 9/19/17. Her criminal background check was not checked by administration until 1/10/18 (over 3 months). Review of her criminal background check revealed that it was clean. Further review of her employee record revealed she had a signed a "Sworn Disclosure Statement" prior to hire.

On 1/16/18 at approximately 10:00 a.m., review of CNA #10's employee file was conducted. CNA #10 was hired on 6/6/17. Her criminal background check was not checked by administration until 1/13/18 (over 7 months). CNA #10 had a clean criminal background check. Further review of her employee record revealed she had a signed a "Sworn Disclosure Statement" prior to hire.

On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the human resource director. OSM #2 stated when a future employee fills out an application, she will decide from the application if they are a good fit for the company. She will then have the applicant come into the facility to introduce them to the

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DON (Director of Nursing). OSM #2 stated she will then run a background check and if the background check comes out clean, she will run their certification. OSM #2 stated a criminal background check must be completed prior to hire.

On 1/16/18 at 11:31 a.m., an interview was conducted with OSM (other staff member) #7, the assistant business office manager. OSM #7 stated she was responsible as of 1/11/18, to ensure certification verifications and criminal background checks were conducted. OSM #7 stated that OSM #1 had walked out during the survey on 1/11/18. OSM #7 stated that the criminal background checks should be done after the job is offered to the applicant. When asked why it is important to run a criminal background check, OSM #7 stated criminal background checks are done to ensure that an applicant does not have a history of assault, have a misdemeanor, or is a sex offender etc. OSM #7 stated, "They have to be suitable to take care of people."

On 1/16/18 at 2:00 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing). ASM #1 stated criminal background checks must be done prior to the applicant's hire. ASM #2 stated the human resources director was responsible and now it will be the assistant business office manager's responsibility.

On 1/16/18 at 2:00 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

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Review of the facility's abuse policy documents in part, the following: "Persons applying for employment with the center will be screened for a history of abuse, neglect, and exploitation, or misappropriation of resident property. This includes but not limited to:

- Employment history
- Criminal background check
- Abuse check with appropriate licensing board and registries, prior to hire
- Documentation of status of any disciplinary actions form (sic) licensing or registration boards and other registries.
- Information from former employers."

F 607 Develop/Implement Abuse/Neglect Policies
SS=E CFR(s): 483.12(b)(1)-(3)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined that facility staff failed to implement abuse policies and screen CNAs (certified nursing assistants) for abuse by failing

F 607

**F607:**

1. Identified Certified Nursing Assistant (C.N.A)'s certification verification obtained and placed in the employee file 1/11/18. Identified CNAs pending violation documents obtained, validated/addressed and placed in the employee file 1/11/18. Identified C.N.A's criminal background checks/Virginia State Police obtained and placed in the employee file 1/11/18.

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| F 607 | Continued From page 18<br>to verify certifications upon hire and certification expiration, and by failing to run criminal background checks within thirty days of hire.<br><br>1. The facility staff failed to implement abuse policies and obtain certification verification for seventeen out of 79 currently employed CNAs (certified nursing assistant). Seventeen out of the 79 currently employed CNAs had expired certifications in their employee file. The CNAs included CNA #3, CNA #5, CNA #7 and CNA #19 through 32.<br><br>2. The facility staff failed to implement abuse policies and obtain certification verifications prior to hire for three of 79 currently employed CNAs, CNA #3, CNA #10 and CNA #11. All three CNAs were found to have a pending violation against their certification and were providing direct care to residents.<br><br>3. The facility staff failed to implement abuse policies and obtain criminal background checks from the Virginia State Police Department within thirty days of hire for two of 79 currently employed CNAs, CNA #3 and CNA #10.<br><br>The findings include:<br><br>1. On 1/10/18 at 1:15 p.m. surveyors entered the facility to investigate a two-day complaint. During the course of investigation an immediate jeopardy was identified and a substandard review and expanded survey was initiated.<br><br>Part of the substandard review is to ensure all currently employed CNAs (certified nursing assistants) have registry verification of their | F 607 | 2. A quality review of current CNA employee files by the Human Resources Coordinator (HRC) completed to ensure CNA certification verification is current, pending violation documents obtained and addressed as applicable and validated by Executive Director (ED)/Director of Nursing Services (DON) with documentation in the employee file per regulation. CNA's without a current certification and/or pending violations to be removed from the schedule until certification and/or pending violation documents obtained and validated by the ED/DON with documentation in the employee file per regulation prior to accepting an assignment.<br>A quality review of current CNA employee files by the HRC completed to ensure criminal background checks/Virginia State Police is current, and validated by the ED/DON with documentation in the employee file within 30 days | |

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certifications. A list of currently employed CNAs was requested on 1/10/18 at approximately 5:30 p.m. with their employee file.

On 1/11/18 at approximately 9:00 a.m., review of the CNA employee files was conducted. Less than 50 percent of the 79 currently employed CNAs had an up-to-date certification in their employee file.

On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the human resources director. When asked who was responsible for verifying certifications, OSM #2 stated she verified certifications. When asked about the process followed for verifying certifications, OSM #2 stated when a future employee fills out an application, she will decide from the application if they are a good fit for the company. She will then have the applicant come into the facility to introduce them to the DON (Director of Nursing). OSM #2 stated she will then run a background check and if the background check comes out clean, she will run their certification. When asked if there were any other times, she would verify certifications, OSM #2 stated she has a computer system (payroll program) that alerts her when an employee's certification needs to be verified. When asked why certifications need to be verified, OSM #2 stated certifications need to be verified to ensure that certifications are not expired and to ensure there are no violations against the certification. When asked where certifications should be filed, OSM #2 stated certifications should be filed in the employee's file. OSM #2 stated she would try to find additional certifications.

On 1/11/18 at approximately 3:00 p.m., OSM #2

of hire. CNAs without a current criminal background check to be removed from the schedule until a background check is obtained, and validated by the ED/DON with documentation in the employee file prior to accepting an assignment.

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handed this writer a stack of certifications that were verified on 9/10/17. OSM #2 stated she had realized that some CNAs had expired certifications in their employee file and she had printed out current certifications from the department of health professions website. OSM #2 stated if a current certification was not in the employee file or in the stack of paper just given to this writer, then she did not have them.

On 1/11/18 at approximately 3:00 p.m., review of the stack of CNA certifications was conducted. Seventeen out of the 79 currently employed CNAs did not have their certification verified. Seventeen out of the 79 current CNAs had expired certifications in their employee file. The CNAs included CNA #3, CNA #5, CNA #7 and CNA #19 through 32. Review of the as-worked schedule from the past two weeks prior to entrance, revealed that the 17 CNAs identified had been directly working with residents and providing care.

On 1/11/18 at 4:00 p.m., facility staff presented current certification verifications of the identified 17 CNAs. The certifications were printed from the DHP (Department of Health Professions) website on 1/11/18. All identified CNA's had a current certification.

On 1/11/18 at 4:44 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated the human resources director was responsible for verifying certifications. When asked why certifications should be verified, ASM #1 stated certifications should be verified to ensure a certification is current and in good-standing. ASM #1 stated certifications should be checked before her interview with the

3. HRC re-educated by the ED/DON/designee regarding ensuring CNA certification verification is current, pending violation documents reviewed/addressed as applicable and validated by the ED/DON prior to accepting an assignment to ensure implementation of Abuse Policy per regulation.
HRC re-educated by the ED/DON/designee regarding new CNA applicant's certification verification to be reviewed, pending violation documents reviewed/addressed as applicable and validated by the ED/DON per regulation upon hire and prior to extending an offer of employment to ensure implementation of Abuse Policy per regulation.
HRC re-educated by the ED/DON/designee regarding ensuring criminal background checks/Virginia State Police is obtained, placed in the

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| | 495362 | A. BUILDING _____ B. WING _____ | C 01/16/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ASHLAND NURSING AND REHABILITATION | 906 THOMPSON STREET ASHLAND, VA 23005 |

| (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 |
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| F 607 | Continued From page 21<br>applicant. ASM #1 stated she cannot interview the applicant without the employee file and a copy of their current certification. ASM #1 stated all CNAs should have a current certification in their employee file.<br><br>On 1/11/18 at 4:44 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.<br><br>2. The facility staff failed to obtain certification verifications prior to hire for three of 79 currently employed CNAs, CNA #3, CNA #10 and CNA #11. All three CNAs were found to have a pending violation against their certification that had not been investigated by administration. All three CNAs had directly worked with residents by providing care.<br><br>On 1/11/18 at approximately 9:00 a.m., review of CNA #3's employee file was conducted. CNA #3 did not have a current certification in her employee file. CNA #3's hire date was 9/19/17.<br><br>On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the human resources director. When asked who was responsible for verifying certifications, OSM #2 stated she verified certifications. When asked about the process followed for verifying certifications, OSM #2 stated when a future employee fills out an application, she will decide from the application if they are a good fit for the company. She will then have the applicant come into the facility to introduce them to the DON (Director of Nursing). OSM #2 stated she will then run a background check and if the | F 607 | employee file and validated by ED/DON within 30 days of hire to ensure implementation of Abuse Policy per regulation. HRC re-educated by the ED/DON/Designee regarding CNAs whose certification is due for renewal within the month are to be provided a letter requiring signature | |

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| F 607 | Continued From page 22<br>background check comes out clean, she will run their certification. When asked why certifications need to be verified, OSM #2 stated that certifications need to be verified to ensure certifications are not expired and to ensure there are no violations against the certification. When asked where certifications should be filed, OSM #2 stated certifications should be filed in the employee's file.<br><br>On 1/11/18 at approximately 3:00 p.m., OSM #2 handed this writer a stack of certifications that were verified on 9/9/17 through 9/10/17. OSM #2 stated she had realized some CNAs had expired certifications in their employee file and she had printed out current certifications from the department of health professions website. CNA #3's current certification could not be found in the stack of certifications. OSM #2 stated if a current certification was not in the employee file or in the stack of paper just given to this writer, then she did not have them.<br><br>On 1/11/18 at 4:00 p.m., facility staff presented the current certification verification for CNA #3. The certification verification was printed from the Department of Health Professions Website on 1/11/2018. CNA #3 had a pending violation against her certification that had not been resolved by the Board of Nursing. The following was documented on CNA #3's certification: "Additional public information: YES..."YES" means that there is information the Department of Health must make available to the public pursuant to 54.1-2400. G The Code of Virginia; please note that this may also include proceedings in which a finding of "no violation was made." | F 607 | communicating certification renewal due date with documentation in the employee file. CNA's without proof of current certification to be removed form the schedule until proof of current certification is provided and validated by the ED/DON with documentation in the employee file. ED/DON to be provided a list monthly with identified CNAs to ensure implementation of Abuse Policy per regulation. Human Resources re-educated by the ED/DON/designee regarding responsibility for maintaining the appropriate documentation in the CNA employee file and providing a copy of the Quality Monitor monthly to the DON and ED to ensure implementation of Abuse Policy per regulation. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 607 | Continued From page 23 | F 607 | 4. HRC/designee to conduct random quality monitoring of C.N.A employee files to ensure certification verification is current, located in the employee and validated by the ED/DON upon hire to ensure implementation of Abuse Policy per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated. HRC/designee to conduct random quality monitoring of C.N.A employee files to ensure new CNA applicant's certification verification reviewed and validated by the ED/DON upon hire and prior to extending an offer of employment to ensure implementation of Abuse Policy per regulation weekly x 4 weeks, twice monthly x 4 | |

On 1/11/18 at 4:20 p.m., further interview was conducted with OSM #1. OSM #1 was asked about the process followed if she were to verify a CNA's certification and found a "YES" on their certification indicating that there may be a pending violation against their certification. OSM #1 stated she would not know what to do at that time. OSM #1 stated she would go to the DON about the certification. OSM #1 stated the pending violation may also need to be investigated by the administrator. OSM #1 could not recall a time when a CNA had a pending violation against their certification.

On 1/11/18 at 4:23 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON. The DON was asked about her involvement in the hiring and certification verification process. ASM #2 stated after the application was reviewed by human resources, she would have the applicant come in for an interview and introduce the applicant to the administrator. ASM #2 stated if they liked the applicant, they would run a background check. If the background check was clean, then human resources would verify the certification. ASM #2 stated the administrator would make the final decision to hire an applicant. ASM #2 was not aware of a time where they hired an applicant with a pending violation against their certification. ASM #2 could not recall verifying CNA #3's certification. ASM #2 stated if a CNA had a pending violation, it would be the administrator's decision whether the applicant was hired.

On 1/11/18 at 4:44 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated the human resources director was

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| F 607 | Continued From page 24 | F 607 | | |

responsible for verifying certifications. When asked why certifications should be verified, ASM #1 stated certifications should be verified to ensure a certification is current and in good-standing. ASM #1 stated certifications should be checked before her interview with the applicant. ASM #1 stated she cannot interview the applicant without the employee file and a copy of their current certification. ASM #1 stated all CNAs should have a current certification in their employee file. When asked about the process followed if a CNA had a pending violation against their certification, ASM #1 stated her decision to hire an applicant would depend on the violation. ASM #1 stated if the violation was still pending, she would not hire that person until she found additional information from the Board of Nursing. When asked if she had recently hired a CNA that had a pending violation against their certification, ASM #1 stated, "No, not recently. Not at this job at all." When asked what she could recall about hiring CNA #3, ASM #1 stated she was not aware that CNA #3 had a pending violation against her certification. ASM #1 stated that CNA #3 will be suspended until she receives additional information regarding her pending violation from the Board of Nursing.

On 1/11/18 at 5:25 p.m., the Administrator and DON (Director of Nursing) were able to evidence they had suspended CNA #3 until further investigation. The Administrator and DON were able to evidence they removed this CNA from the working schedule dated 1/11/18 through 1/16/18.

On 1/16/18 at 9:30 a.m., further interview was conducted with ASM #2, the DON. When asked what CNA #3's violation was on her certification, ASM #2 stated her pending violation was from

weeks, then monthly, PRN and as indicated.
HRC/designee to conduct random quality monitoring of C.N.A employee files to ensure criminal background checks/Virginia State Police is obtained, placed in the employee file and validated by ED/DON within 30 days of hire per regulation to ensure implementation of Abuse Policy per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.
HRC/designee to conduct random quality monitoring regarding CNAs whose certification is due for renewal within the month are to be provided a letter requiring signature communicating certification renewal due date with documentation in the employee file to ensure implementation of Abuse Policy per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.

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2013 and no violation was found. ASM #2 stated the board of nursing had not yet taken the pending violation off the website. ASM #2 stated she could not obtain additional information regarding the violation. ASM #2 stated she had also found two additional CNAs who had pending violations on their certification but they were clear to work. ASM #2 was asked to provide evidence that these CNAs had no violations on their certification. ASM #2 stated she would try to get in touch with the department of health professions.

Review of CNA #3's time card revealed that she had worked approximately 70 shifts as a CNA providing direct patient care from 10/05/17 until 1/11/18 (when CNA #3 was suspended). Further review of the time card revealed CNA #3 was removed from the schedule on 1/11/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #3, documented the following: "Employee was suspended via telephone secondary to violation of level 2 -#30. Employee was told that she cannot clock in or return to work until the investigation is complete. Employee verbalized understanding and stated she had a letter to bring in from the board."

Also on 1/11/18 at 4:00 p.m. the facility staff presented documentation evidencing two additional CNAs, CNA #10 and CNA #11 had been identified as having pending violations on their certifications.

1. CNA #10 was hired on 6/6/17 and her certification was not verified until 9/10/17. Review of her time card revealed she had worked approximately 73 shifts as a CNA providing direct

HRC/designee to conduct random quality monitoring of employee files regarding CNA's without proof of current certification to be removed form the schedule until proof of current certification is provided and validated by the ED/DON with documentation in the employee file to ensure implementation of Abuse Policy per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance: 3-2-18

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patient care from 9/21/17 until 1/12/18 (when CNA #10 was suspended). Further review of the time card revealed CNA #10 was removed from the schedule on 1/12/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #10, documented the following: "Employee was suspended secondary to level 2 -#30. Employee was informed that she is suspended pending investigation. Employee stated she has a letter at home clearing her. Employee was informed to bring in. Employee comments: I went to the board of nursing for verbal abuse and they cleared it and said I wasn't guilty and cleared me from the verbal abuse and nothing was on my certification."

2. CNA #11 was hired on 2/2/15 and her certification was not verified until 9/9/17. Review of her timecard revealed that she had worked approximately 83 shifts as a CNA providing direct patient care from 9/27/17 until 1/12/18 (when she was removed from the schedule). Further review of the time card revealed that CNA #10 was removed from the schedule on 1/12/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #11, documented the following: "Employee was suspended secondary to level 2 -#30. Employee was informed that she is suspended pending investigation. Employee stated she has a letter at home clearing her. Employee was informed to bring it in. Employee comments: I went to the state boards for having to put a woman down on the floor from a sit to stand because I went to put the other strap on and the chair moved. And I never had used a sit to stand before and I was told I could hook them up by myself and then go get someone to transfer."

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| F 607 | Continued From page 27 | F 607 | | |

On 1/16/18 at 11:10 a.m., an interview was conducted with OSM (other staff member) #6, the Discipline Specialist for the Virginia Board of Nursing. OSM #6 stated that CNA #3, CNA #10, and CNA #11 had no violation pending on their certification. OSM #6 stated when a certified professional has a pending violation on their certification, an informal conference with the certified professional and board of nursing will occur. OSM #6 stated that is when the board of nursing will review the case and decided whether the certified professional is guilty of a violation or cleared. OSM #6 stated that all CNAs should have received a letter from the board stating that no violation was found. OSM #6 stated it takes a while for this information to come off the website. When asked the reason for each CNA to be presented to the board, OSM #6 stated, "That is not public information." OSM #6 could not give any information of when each CNA was cleared from their pending violation.

On 1/16/18 at 2:00 p.m., ASM #1, the administrator and ASM #2, the DON were made aware of the above findings.

3. The facility staff failed to obtain criminal background checks from the Virginia State Police within thirty days of hire for two of 79 currently employed, CNA #3 and CNA #10.

On 1/11/18 at approximately 10:30 a.m., review of CNA #3's employee file was conducted. CNA #3 was hired on 9/19/17. Her criminal background check was not checked by administration until 1/10/18 (over 3 months). Review of her criminal background check revealed that it was clean.

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| F 607 | Continued From page 28 | F 607 | | |

Further review of her employee record revealed she had a signed a "Sworn Disclosure Statement" prior to hire.

On 1/16/18 at approximately 10:00 a.m., review of CNA #10's employee file was conducted. CNA #10 was hired on 6/6/17. Her criminal background check was not checked by administration until 1/13/18 (over 7 months). CNA #10 had a clean criminal background check. Further review of her employee record revealed she had a signed a "Sworn Disclosure Statement" prior to hire.

On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the human resource director. OSM #2 stated when a future employee fills out an application, she will decide from the application if they are a good fit for the company. She will then have the applicant come into the facility to introduce them to the DON (Director of Nursing). OSM #2 stated she will then run a background check and if the background check comes out clean, she will run their certification. OSM #2 stated a criminal background check must be completed prior to hire.

On 1/16/18 at 11:31 a.m., an interview was conducted with OSM (other staff member) #7, the assistant business office manager. OSM #7 stated she was responsible as of 1/11/18, to ensure certification verifications and criminal background checks were conducted. OSM #7 stated that OSM #1 had walked out during the survey on 1/11/18. OSM #7 stated that the criminal background checks should be done after the job is offered to the applicant. When asked why it is important to run a criminal background

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check, OSM #7 stated criminal background checks are done to ensure that an applicant does not have a history of assault, have a misdemeanor, or is a sex offender etc. OSM #7 stated, "They have to be suitable to take care of people."

On 1/16/18 at 2:00 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing). ASM #1 stated criminal background checks must be done prior to the applicant's hire. ASM #2 stated the human resources director was responsible and now it will be the assistant business office manager's responsibility.

On 1/16/18 at 2:00 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Review of the facility's abuse policy documents in part, the following: "Persons applying for employment with the center will be screened for a history of abuse, neglect, and exploitation, or misappropriation of resident property. This includes but not limited to:

- Employment history
- Criminal background check
- Abuse check with appropriate licensing board and registries, prior to hire
- Documentation of status of any disciplinary actions form (sic) licensing or registration boards and other registries.
- Information from former employers."

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| F 609 | Reporting of Alleged Violations | F 609 | |

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| F 609 SS=D | Continued From page 30 CFR(s): 483.12(c)(1)(4) | F 609 | | |

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined the facility staff failed to notify the appropriate state agency of an injury of unknown origin, resulting in serious bodily injury in a timely manner for one of five residents in the survey sample, Resident #1.

F609: Reporting of Alleged Violations

1. Resident #1 re-admitted 2/7/18. Facility Reported Incident (FRI) submitted 1/08/18. No further events requiring a FRI have occurred.

2. Quality review of event reports in the last 30 days by the Executive Director (ED)/Director of Nursing Services (DON) completed to ensure residents with injury of unknown origin, resulting in serious bodily injury are reported timely to the appropriate state agency per regulation. Follow up based on findings.

3. ED and DON re-educated by the Regional Vice President of Operations (RVPO) regarding ensuring residents with injury of unknown origin, resulting in serious bodily injury are reported to the appropriate state agency timely per regulation.

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The facility staff failed to notify the appropriate state agency within the two hour required timeframe following Resident #1's egregious injury of second and third degree burns to the face, hand and chest.

The findings include:

Resident #1 was admitted to the facility on 3/11/15 and readmitted on 8/15/17 with diagnoses that included but were not limited to traumatic brain injury, dementia and seizures. The most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 10/3/17 coded the resident as having a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as being able to complete activities of daily living independently. The resident was coded as being 5'6" tall.

Review of the care plan initiated on 8/21/17 and revised on 9/12/17 documented, "Focus. (Name of Resident #1) has the potential for injury r/t (related to) Confusion, epilepsy (seizures), Psychoactive drug use, poor safety awareness and Wandering AEB (as evidenced by) a hx / (history) of falls. Interventions. The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate glare-free light: a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach."

Review of the SBAR (situation, background, assessment and recommendation) dated 1/8/18 at 8:45 a.m. documented, "BACKGROUND Resident Description Primary diagnoses TBI

4. ED/DON/designee to conduct quality monitoring through morning clinical meeting of event reports to ensure residents with injury of unknown origin, resulting in serious bodily injury are reported to the appropriate state agency timely per regulation 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated. ED/DON/designee to conduct quality monitoring through morning clinical meeting of the 24 hour report to ensure residents with injury of unknown origin, resulting in serious bodily injury are reported to the appropriate state agency timely per regulation 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 3-2-18.

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(traumatic brain injury), seizures from TBI, past alcohol use. Resident Evaluation: 1. Mental Status Evaluation (compared to baseline; check all that you observe) Decreased level of consciousness (sleepy, lethargic) [was checked]. Functional Status Evaluation (compared to baseline; check all that you observe) Decreased mobility. Needs more assistance with ADLs (activities of daily living). Weakness (general) [were all checked]. 8. Skin Evaluation. Abrasion. Burn. Discoloration Wound (were all checked). Describe symptoms or signs. (R) [right] side of face + (plus) (R) hand noted with edema (swelling), burn d/t (due to) resident layed (sic) on heater. 10. Neurological Evaluation. Decreased level of consciousness. Weakness or hemiparesis (were all checked). APPEARANCE Summarize your observations and evaluations. Resident appeared to have burns to (R) side of face + (R) hand also appeared to have had a stroke very weak + lethargic (with) yellow drainage to face."

Review of the skin evaluation form dated 1/8/18 documented, "Blister - (R) eye/ (R) forehead/ (R) cheek - (L) 3 (sic) or 4th finger - (R) top of hand - Reddened areas - under (R) chest wall. Open area - sacrum - unable to assess (L) side of body due to arrival of EMS (emergency medical service) + difficulty (with) positioning."

Review of the nurse's notes dated 1/8/18 at 4:20 p.m. documented, "Aide informed nurse to come to room to check on resident because she observed resident lying on heater (R) [right] side of face + hand was on heater noted yellow drainage coming from hand, this nurse came in to room to assess resident called residents (sic) name (no) answer observed (R) side of face +

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(R) hand swollen + discolored yellow substance appeared to be coming from face. (R) side weak noted leaning to that side resident transferred to bed, cleaned up vs (vital signs) obtained 90/86 (blood pressure) - 116 (pulse) - 18 (respirations) - 104 (temperature). O (sic) [oxygen] - 93% on 2 L (liters) O2 (oxygen) 911 called EMT (emergency medical transport) arrived resident to (name of hospital) MD (medical doctor) aware at this time RP (responsible party) notified, prior to incident this AM @ approx (at approximately) 815 AM (8:15 a.m.), this writer observed resident sitting in chair by heater + appeared (sic) sleep @ approx 445 AM (4:45 a.m.) did not appear to be in any distress @ the time, talked (with) RP in regards to residents (sic) condition RP states she is aware that resident has had a decline, states hospital is trying to rule out bleeding of brain and or stroke will keep up updated + will be in town tonight but will go to hospital to see resident in AM."

Review of the facility reported incident (FRI) revealed the FRI was received at the state agency at 10:13 p.m. approximately 14 hours after the injury occurred.

An interview was conducted on 1/11/18 at 10:50 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked who was responsible to send a FRI to the appropriate state agency, ASM #2 stated, "For the most part (name of ASM #1, the administrator) and I do the reporting. My initial response was to make sure the resident is safe and then to report it to (ASM #1)." When asked when ASM #1 was made aware of Resident #1's injuries, ASM #2 stated, "Maybe about 9:15 (a.m.), 9:30, ten." When asked when a serious injury was to be reported to the state agency, ASM #2 stated, "My

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understanding is that abuse and neglect is two hours. I do know that there have been some changes in the regs (regulations) on the 28th of November and I'm not really solid on those changes."

An interview was conducted on 1/11/18 at 11:40 a.m. with RN (registered nurse) #3, the assistant director of nursing. When asked who was responsible for completing and sending a FRI to the appropriate state agency, RN #3 stated, "I believe the administrator is responsible for completing the FRI but she gets the info (information) from the appropriate department." When asked what the timeframe for reporting was, RN #3 stated, "My reporting is immediately. I called a stat (immediate) so I could get all the nurses and my boss immediately so they know what happened." When asked if she knew the timeframe in which the state agency was to be notified, RN #3 stated, "No."

An interview was conducted on 1/11/18 at 2:45 p.m. with ASM (administrative staff member) #1, the administrator. ASM #1 was asked when a FRI was sent to the state agency. ASM #1 stated, "I send a FRI to (office of licensure and certification) and the ombudsman. If it's abuse, I start my investigation. Well first thing I do is remove the resident from harm and then start the investigation and send it in within five days." When asked when an egregious injury such as the one Resident #1 sustained would be reported to the state agency, ASM #1 stated they had 24 hours. ASM #1 was made aware of the concern at that time.

Review of the facility's policy titled, Abuse, Neglect, Exploitation & Misappropriation"

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documented, "POLICY: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation/or misappropriation of property. The manager of the facility recognizes these rights and thereby establishes the following statements, policies and procedures to protect these rights and to establish a disciplinary policy, which results in the facility and timely treatment of occurrences of resident abuse.
Reporting/Response. Any employee or contracted service providers who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do nor result ins serious bodily injury, to the administrator and other official in accordance with State law. In the absence of the Executive Director, the Direct of of Clinical Services if the designated abuse coordinator. Once an allegation of abuse is reported, the executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulation, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law."

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| F 609 | Continued From page 36 No further information was obtained prior to exit. | F 609 | | |
| F 641 SS=D | Accuracy of Assessments CFR(s): 483.20(g) | F 641 | | |

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined the facility staff failed to accurately complete an MDS (minimum data set) assessment for one of six residents in the survey sample, Resident #5.

The facility staff incorrectly coded the resident's urinary incontinence status on Resident #5's quarterly MDS assessment, with an assessment reference date of 11/21/17.

The findings include.

Resident #5 was admitted to the facility on 6/26/12 with a recent readmission on 3/15/17 with diagnoses that included but were not limited to: multiple sclerosis [MS] (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover, it progresses slowly with increasing disability (1)), muscle weakness, paraplegia (paralysis of the lower limbs (2)), high blood pressure, depression, dysfunction of the bladder, and absence of toe.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/21/17 coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he is

**F641:**

1. Resident #5 Minimum Data Set (MDS) quarterly assessment with an assessment reference date (ARD) of 11/21/17 /modified and re-submitted.

2. Quality Review of current residents with indwelling/supra-pubic catheters completed by the MDS Coordinator/Director of Nursing Services (DON)/designee to ensure the MDS is accurately coded in section H/ Bladder and Bowel, H 0300 Urinary Incontinence is Coded 9, noted rated within the specified ARD to include modifications and re-submission(s) as indicated based on findings.

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| F 641 | Continued From page 37 | F 641 | | |

cognitively intact to make daily decisions. In Section H - Bladder and Bowel, Resident #5 was coded as having an indwelling catheter under "Appliances" and was coded as being "Always Continent" under urinary incontinence.

The physician orders dated 1/1/18 and signed by the physician on 12/30/17, documented in part, "Supra Pubic Catheter care every shift - neurogenic bladder."

A supra pubic catheter is a catheter put into the bladder from the outside above the pubis. (3).

The physician progress notes dated, 12/3/17, documented in part, "He has a suprapubic catheter for neurogenic bladder which he changes himself."

The comprehensive care plan dated, 12/4/17, documented in part, "(Resident #5) has altered bladder elimination r/t (related to) prostate enlargement, history of UTI (urinary tract infections) neurogenic bladder, AEB (as evidenced by) Catheter - per order."

An interview was conducted with RN (registered nurse) #3, the MDS nurse, on 1/11/18 at 10:42 a.m. RN #3 was asked to review Section H of the quarterly MDS with an assessment reference date of 11/21/17. Once reviewed, RN #3 stated, "It's incorrect, it should be coded as 'not rated.' I will make the correction." When asked what reference they use to complete the MDS assessments, RN #3 stated, "The RAI manual."

The RAI (resident assessment instrument) manual from October 2017 documented in part: "Section H - Bladder and Bowel. H 0300 - Urinary

3. MDS Coordinator re-educated by the DON/designee regarding ensuring section H/ Bladder and Bowel, H 0300 Urinary Incontinence is accurately Coded 9, noted rated to reflect the resident's current status and services provided for residents with indwelling/supra-pubic catheters within the specified ARD.

4. MDS Coordinator/DON/designee to conduct quality monitoring of MDS assessments prior to submitting to ensure accuracy of section H/ Bladder and Bowel, H 0300 Urinary Incontinence is accurately Coded 9, noted rated to reflect the resident's current status and services provided for residents with

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| F 641 | Continued From page 38<br>Incontinence - Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days."<br><br>The administrator, director of nursing and the regional director of clinical services were made aware of the above concern on 1/11/18 at 5:32 p.m.<br><br>No further information was provided prior to exit. | F 641 | indwelling/supra-pubic catheters within the specified ARD 3 times weekly x 4 weeks, 2 times weekly x 4 weeks, then weekly and PRN as indicated.<br>Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.<br><br>5. Date of Compliance: 3-2-18 | |
| F 656 SS=D | Develop/implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will | F 656 | | |

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| F 656 | Continued From page 39 | F 656 | | |

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 observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure the comprehensive care plan was implemented for one of 6 residents in the survey sample; Resident #3.

The facility staff failed to ensure a safe environment for Resident #3 including even floors as per the comprehensive care plan to prevent falls. Multiple observations of Resident #3's room revealed an entire 12-inch by 12-inch floor tile missing in the middle of the room.

The findings include:

Resident #3 was admitted to the facility on 7/10/15 with the diagnoses of but not limited to

**F656:**

1. Resident #3 floor tile in resident room replaced.

2. Quality review of resident's with falls within the last 30 days completed by MDS Coordinator/Director of Nursing Services (DON)/designee to ensure care plan intervention(s) accurately reflect the residents' current status and the comprehensive care plan was implemented for residents with falls. Quality review of Resident Rooms for cracked or missing floor tiles completed. Follow up based on findings

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 656 | Continued From page 40 | F 656 | 3. MDS Coordinator re-educated by the DON/designee regarding ensuring care plan intervention(s) accurately reflect the current status and the comprehensive care plan was implemented for residents with falls. Interdisciplinary team (IDT) re-educated by the Executive Director (ED)/Maintenance Director to ensure cracked/missing floor tiles are communicated via Mock Survey rounds and /or documented in the maintenance book. | |

chronic kidney disease, high blood pressure, Alzheimer's Disease, diabetes, and psychosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/17/17. Resident #3 was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 1 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring total care for bathing; extensive care for bed mobility, dressing, toileting, and hygiene; Supervision to limited assistance for ambulation; and as frequently incontinent of bowel and bladder.

On 1/10/18 at 2:30 p.m., 5:11 p.m., 6:10 p.m., and 7:35 p.m.; and on 1/11/17 at 8:30 a.m., Resident #3's room was observed. During each observation an entire 12-inch by 12-inch floor tile was observed missing in the middle of the room.

On 1/11/18 at 8:25 a.m., in an interview with CNA #2 (Certified Nursing Assistant) she stated the resident is ambulatory without the use of a walking assuasive device. When asked about the missing floor tile, CNA #2 stated she was not aware it was missing. When asked if the missing tile would cause a tripping hazard for Resident #3, CNA #2 stated it would. When asked if she ever looks at the resident's care plan, CNA #2 stated no. When informed Resident #3's comprehensive care plan documented the resident should have an even floor surface for safety, and asked if the care plan being followed, CNA #2 stated, "No."

On 1/11/18 at 8:30 a.m., in an interview with LPN #1 (Licensed Practical Nurse) she stated the resident is an ambulatory resident. When asked

4. MDS Coordinator/DON/designee to conduct quality monitoring through morning clinical meeting to ensure care plan intervention(s) accurately reflect the residents current status and the comprehensive care plan was implemented for residents with falls 3 times weekly x 2 weeks, twice weekly x 4 weeks then weekly and PRN as indicated.
ED/Maintenance

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| F 656 | Continued From page 41<br>about the missing floor tile in Resident #3's room, LPN #1 stated she was not aware of it. When asked if this would be a tripping hazard for the resident, LPN #1 stated yes it would be. When asked if she ever looks at the resident's care plan, LPN #1 stated no. When informed Resident #3's comprehensive care plan documented the resident should have an even floor surface for safety, and asked if the care plan was being followed, LPN #1 stated, "No."<br><br>A review of the facility policy, "Plans of Care" documented, ". .. Develop and implement an individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team...."<br><br>On 1/11/18 at 5:33 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey. | F 656 | Director/designee to conduct quality monitoring through Mock Survey rounds to ensure cracked/missing floor tile are communicated via Mock Survey rounds and /or documented in the maintenance book 5 times weekly x 4 weeks, 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated. Cracked or missing tiles repaired as indicated by Quality Review findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by.<br>Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure treatment and care were provided in accordance with | F 684 | 5. Date of Compliance: 3-2-18 | |

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| F 684 | Continued From page 42 | F 684 | **F684:** | |

professional standards of practice, and the comprehensive person-centered care plan for two of six residents in the survey sample, Resident #4, and #2.

1. The facility staff failed to obtain Resident #'s vital signs every shift per physician's order.

2. The facility staff failed to administer a medicated shampoo to treat head lice as ordered for Resident #2 on 10/10/17.

The findings include:

1. Resident #4 was admitted to the facility on 12/21/17 with diagnoses that included but were not limited to altered mental status, muscle weakness, difficulty walking, abnormality of gait, seizure disorder, and unspecified viral hepatitis. Resident #4's most recent MDS (minimum data set) assessment was an admission MDS with an ARD (assessment reference date) of 12/28/17. Resident #4 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the Brief Interview for Mental Status Exam. Resident #4 was coded as requiring supervision only, with most ADLS (activities of daily living).

Review of Resident #4's physician order sheet revealed the following order signed by the physician on 12/22/17, " Vital signs: (frequency) TEMP (temperature) Q shift (every shift), Pulse Q shift, Resp (Respirations) Q shift, Blood Pressure Q shift."

Review of Resident #4's December 2017 and January 2018 MARS (Medication Administration Record) and TARS (Treatment Administration

1. Resident #2's received medication treatment for head lice per physician order on and did not suffer any s/s of adverse effects.
Resident #4 Vital Signs every shift discontinued per physician order.

2. Quality review of current residents completed by the Director of Nursing (DON)/Unit Manger (UM) to ensure medication treatment for head lice is administered per physician order without omission on the Medication Administration Record (MAR).
Quality review completed by the DON/UM/designee to ensure vital signs obtained per physician order without omission on the MAR.
Follow up based on findings.

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Record) failed to reveal evidence that vital signs were checked per physician's order.

Review of Resident #4's vital sign log located in his clinical record revealed his admission vital signs on 12/21/17. The following was documented: BP (blood pressure): "124/84, Pulse: 80, Respirations: 18, Temp (temperature): 99.1."

Review of Resident #4's skilled nursing notes revealed that vital signs were taken on the following dates and shifts:

12/22/17 3-11 shift;
12/24/17 11-7, 7-3 and 3-11 shifts;
12/26/17 11-7 shift,
12/2/17 11-7 shift;
1/05/17 11-7 shift;
1/06/17 11-7 and 7-3 shifts;
1/08/17 7-3 and 3-11 shifts.

No further vital signs could be found in the clinical record for Resident #4. All above vital signs were within normal limits.

Review of Resident #4's care plan dated 12/22/17 and revised 1/10/18, revealed no interventions to monitor vital signs every shift.

On 1/11/18 at 11:15 a.m., an interview was conducted with LPN (licensed practical nurse) #1 and LPN #2. When LPN #1 was asked why vital signs would be checked every shift, LPN #1 stated vital signs would be checked every shift for any change in condition, if a resident is on a medication regimen that could affect vital signs such as a blood pressure medication, or if there is a doctor's order in the chart. When asked

3. Licensed Nurses re-educated by the DON/UM/designee regarding ensuring vital signed are obtained per physician order without omission on the MAR. Licensed Nurses re-educated by the DON/UM/designee regarding ensuring medication treatment for head lice is administered per physician order without omission on the MAR.

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where every (Q) - shift vital signs are documented, LPN #1 stated that Q shift vital signs are documented on the front of the skilled nursing notes or written in the note. LPN #1 stated there is also a vital sign log in the residents' charts where nurses could document vital signs. When asked who was responsible for obtaining vital signs, LPN #1 stated the CNAs (certified nursing assistants) were designated to obtain the vital signs, but nurses are responsible for ensuring vital signs are obtained. LPN #1 stated she was not Resident #4's nurse. LPN #2 stated that she was Resident #4's nurse. When asked why Resident #4 was on vital signs every shift, LPN #2 stated the only reason Resident #4 received vital signs every shift was because he is a skilled resident. When asked what it meant if there were some days and shifts that vital signs were missing from the clinical record, LPN #2 stated, "If it was not documented, then it wasn't done."

On 1/11/18 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Physician Orders" did not address the above concerns. No further information was presented prior to exit.

2. The facility staff failed to administer a medicated shampoo to treat head lice (tiny insects that feed on blood from the human scalp) [1] as ordered for Resident #2 on 10/10/17.

Resident #2 was admitted to the facility on 9/24/16 with diagnoses that included, but were

4. DON/UM/designee to conduct quality random monitoring to ensure medication treatment for head lice is administered per physician order without omission on the MAR 5 times weekly x 4 weeks, 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated. Quality monitoring schedule modified based on findings.
DON/UM/designee to conduct quality random monitoring to ensure vital signs obtained per physician order without omission on the MAR 5 times weekly x 4 weeks, 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated. Quality monitoring scheduled modified based on findings.

5. Date of Compliance: 3-2-18

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not limited to, dementia, acute kidney failure, dehydration and aphasia (difficulty finding words).

Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/8/17, coded Resident #2 as being able to answer the questions provided on her BIMS (brief interview for mental status). The staff assessment for Resident #2's cognitive ability for daily decision making coded Resident #2 as a three (3), indicating that Resident #2 was cognitively severely impaired.

On 1/10/18 at 6:45 p.m. Resident #2's room was observed with a cart outside of the door containing personal protective equipment (PPE) and a sign that documented Resident #2 was on contact precautions.

A review of Resident #2's physician orders revealed, in part, the following physician order, "10/10/17. Rid X (head lice treatment) [2] treatment to head. Dx (diagnosis) head lice. R/t (related to) lice. Repeat in 14 days." Signed and dated by physician on 10/10/17.

A review of Resident #2's progress notes revealed, in part, the following nursing notes:
- "10/10/17. Resident asses (sic) for lice. Found lice. MD (medical doctor) aware. New order for Rid X treatment to head. Repeat in 14 days. RP (responsible party) aware."
- "10/10/17. Resident was treated with rid x treatment. Clothes & (and) room fumigated. Repeat tx (treatment) in 14 days."

Further review of Resident #2's clinical record did not reveal any documentation to evidence that

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Resident #2 had received follow up treatment 14 days following the initial treatment.

On 1/10/17 at 7:35 p.m. an interview was conducted with CNA (certified nursing assitant) #18. CNA #18 was asked why Resident #2 was on isolation. CNA #18 stated, "She has head lice."

On 1/11/18 at 2:16 p.m. an interview was conducted with RN (registered nurse) #4. RN #4 was asked why Resident #2 was on isolation. RN #4 stated, "She (Resident #2) has head lice." RN #4 was asked if Resident #2 had received the treatments for head lice in October. RN #4 reviewed Resident #2's progress notes and stated the nurse had documented a treatment had been applied on 10/10/17. RN #4 reviewed Resident #2's October and November MARs (medication administration records) and TARs (treatment administration records) and stated there was no documentation to evidence Resident #2 had received the 2nd Rid X treatment as ordered on 10/10/17. RN #4 was asked what should have happened. RN #4 stated, "The order should have been followed as written."

On 1/11/18 at 5:35 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings at this time and a policy regarding following physician orders was requested.

A review of the facility policy titled "Physician Orders" revealed, in part, the following documentation; "ROUTINE ORDERS. A Nurse

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| F 684 | Continued From page 47<br>may accept a telephone order from the Physician, Physician Assistant or Nurse Practitioner. The order shall be repeated back to the physician for his/her verbal confirmation. The nurse shall sign off the orders upon completion or verification of transcription."<br><br>No further information was provided prior to the end of the survey process<br><br>[1] This information was obtained from the following website; https://www.mayoclinic.org/diseases-conditions/head-lice/symptoms-causes/syc-20356180<br><br>[2] This information was obtained from the following website; https://www.ridlice.com/en/rid-lice-products/lice-treatment-kits/ | F 684 | | |
| F 689 SS=K | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that staff failed to ensure adequate supervision and an environment free from accident hazards for three of six residents in the survey sample, (Resident | F 689 | **F689: Free of Accident Hazards/Supervision/Devices**<br><br>1. Resident #1 re-admitted 2/07/18 care and services being provided per physician orders. Special care plan with family 2/08/18. Resident #3 floor tile in resident room replaced. Resident #5 bathroom broken/missing tiles replaced. Identified PTAC Units model number AZ22EO9D5BM2 in resident rooms completed by a certified outside vendor on 1/09/18. Identified PTAC units mechanical thermostat stop adjusted to the lowest position in order to prevent the thermostat from allowing the air to rise to a higher unsafe temperature ensuring resident's safety. | |

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| F 689 | Continued From page 48<br>#1, Resident #3 and Resident #5). Resident #1 sustained third and second degree burns on 1/8/18 to the right side of the face, back of the right hand, chest and left shoulder after becoming unconscious and slumping over onto the PTAC (packaged terminal air conditioner [a wall mounted heating and cooling unit]) model number AZ22EO9D5BM2 in his room. The facility had 37 model number AZ22EO9D5BM2 PTAC units in the facility, accessible to residents with ambient air temperatures sufficient to cause tissue injury, resulting in the identification of immediate jeopardy.<br><br>1. On 1/8/18, Resident #1 received third degree burns on the right side of his face, the top of his right hand and second degree burns on the chest and left shoulder after becoming unconscious and slumping over onto the PTAC [model number AZ22EO9D5BM2] in his room. Resident #1 required transfer to a local hospital for treatment, and admission to the intensive care unit with ten percent total body surface burns. On 1/10/18 the ambient air temperature of the PTCA unit in Resident #1's room was obtained, by OSM (other staff member) #4, the maintenance technician, using a facility laser thermometer, following the unit's temperature being set to high heat. OSM #4 easily set the PTCA unit to high heat and the high heat setting on the PTCA unit was easily accessible to residents to adjust. The temperature was 133 degrees Fahrenheit (F). When the surveyor's held the back of their hands to the unit, within 30 seconds it was too hot to keep the hand on the unit. The facility currently had 37 model number AZ22EO9D5BM2 PTAC units in resident rooms, accessible to residents. Random observation and ambient air | F 689 | 2. Quality review of resident rooms with identified PTAC model number AZ22EO9D5BM2 completed by the Maintenance Director/designee to ensure mechanical thermostat stop adjusted to the lowest position when in heat mode in order to prevent the thermostat from allowing the air to rise to a higher unsafe temperature ensuring resident's safety. Follow up based on findings.<br>Quality review of resident rooms by the Maintenance Director/designee for cracked or missing floor tiles completed to ensure resident's safety. Follow up based on findings.<br>Quality review of resident bathrooms by the Maintenance Director/designee for cracked or missing floor tiles completed to ensure resident's safety. Follow up based on findings. | |

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temperature checks of PTAC units in resident rooms, revealed PTCA units with ambient air temperatures ranging from 118 to 165 degrees Fahrenheit (F), temperatures sufficient to cause tissue injury, resulting in the identification of immediate jeopardy at a pattern. After receipt and verification of the facility plan of correction, the immediate jeopardy was abated and the deficiency was assigned a level III isolated.

2. The facility staff failed to ensure a safe environment for Resident #3 including even floors as per the comprehensive care plan to prevent falls. Multiple observations of Resident #3's room revealed an entire 12-inch by 12-inch floor tile missing in the middle of the room.

3. The facility staff failed to ensure a safe environment in the resident's bathroom for one of six residents in the survey sample, Resident #5. Observation of Resident #5's bathroom revealed broken and missing tiles. The broken tiles had sharp pointed edges and some tiles pushed into the wall.

The findings include:

1. Resident #1 was admitted to the facility on 3/11/15 and readmitted on 8/15/17 with diagnoses that included but were not limited to traumatic brain injury, dementia and seizures. The most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 10/3/17 coded the resident as having three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as completing activities of daily living independently.

3. Maintenance Director re-educated by the Executive Director (ED) regarding ensuring PTAC model number AZ22EO9D5BM2 mechanical thermostat stop adjusted to the lowest position when in heat mode in order to prevent the thermostat from allowing the air to rise to a higher unsafe temperature ensuring resident's safety.
Maintenance Director re-educated by the ED regarding ensuring resident rooms and bathroom are free from missing/broken/cracked tiles ensuring resident's safety.
Interdisciplinary Team re-educated by the ED/Director of Nursing Services (DON) to ensure resident safety while the PTAC model number AZ22EO9D5BM2 when in heat mode and maintaining the mechanical thermostat stop adjusted to the lowest position in order to prevent the air from rising to a higher unsafe temperature.
Resident Council re-educated by the ED/DON during the months of February and March regarding risk of injury when using PTAC units when in heat mode.

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Review of the care plan initiated on 8/21/17 and revised on 9/12/17 documented, "Focus. (Name of Resident #1) has the potential for injury r/t (related to) Confusion, epilepsy (seizures), Psychoactive drug use, poor safety awareness and Wandering AED (as evidence by) a hx (history) of falls. Interventions. The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate glare-free light: a working and reachable call light, the bed in low position at night, handrails on walls, personal items within reach."

Review of the physician's notes dated 11/7/17 did not evidence any significant change in Resident #1's condition.

Review of the physician's orders dated and signed on 12/31/17 did not evidence any recent changes in the resident's medications.

Review of the nurses' notes from 1/1/18 to 1/7/18 did not evidence any changes in the resident's condition.

Review of the SBAR (situation, background, assessment and recommendation) dated 1/8/18. With a time of 8:45 a.m. documented, "BACKGROUND Resident Description Primary diagnoses TBI (traumatic brain injury), seizures from TBI, past alcohol use. Resident Evaluation: 1. Mental Status Evaluation (compared to baseline; check all that you observe) Decreased level of consciousness (sleepy, lethargic) [was checked]. Functional Status Evaluation (compared to baseline; check all that you observe) Decrease mobility. Needs more assistance with ADLs (activities of daily living).

4. Maintenance Director/designee to complete quality monitoring through mock survey rounds 5 times a week for 4 weeks, weekly x4 weeks then monthly and PRN to ensure PTAC model number AZ22EO9D5BM2 units mechanical thermostat stop adjusted to the lowest position when in heat mode in order to prevent the air from rising to a higher unsafe temperature ensuring residents safety.
Maintenance Director/designee to complete quality monitoring through mock survey rounds for residents who are non-ambulatory and/or unable to be educated with a BIMS less than 13 regarding PTAC model number AZ22EO9D5BM2 units mechanical thermostat stop adjusted to the lowest position when in heat mode in order to prevent the air from rising to a higher unsafe temperature ensuring residents safety twice daily 5 times a week for 4 weeks, weekly x4 weeks then monthly and PRN.
Maintenance Director/ED/designee to complete random quality monitoring regarding ensuring resident rooms and bathroom are free from missing/broken/cracked tiles ensuring resident's safety 5 times a week for 4 weeks, weekly x4 weeks then monthly and PRN.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 3-2-18.

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Weakness (general) [were all checked]. 8. Skin Evaluation. Abrasion. Burn. Discoloration Wound (were all checked). Describe symptoms or signs. (R) [right] side of face + (R) hand noted with edema (swelling), burn d/t (due to) resident layed (sic) on heater. 10. Neurological Evaluation. Decreased level of consciousness. Weakness or hemiparesis (were all checked). APPEARANCE Summarize your observations and evaluations. Resident appeared to have burns to (R) side of face + (R) hand also appeared to have had a stroke very weak + lethargic (with) yellow drainage to face."

Review of the skin evaluation form dated 1/8/18 documented, "Blister - (R) eye/ (R) forehead/ (R) cheek - (L) 3 (sic) or 4th finger - (R) top of hand - Reddened areas - under (R) chest wall. Open area - sacrum - unable to assess (L) side of body due to arrival of EMS (emergency medical service) + difficulty (with) positioning."

Review of Resident #1's emergency department visit dated 1/8/18 at 9:12 a.m. documented in part, "History of Present Illness. The patient presents with major trauma. The onset was just prior to arrival. The course of symptoms is constant. Type of injury: burn. The location where the incident occurred was at home. The character of symptoms is redness and swelling. Associated symptoms: altered level of consciousness. 57 y.o. (year old) DNR (do not resuscitate) male with PMHx (prior medical history) seizures, TBI who presented to the ED (emergency department) via EMS as DELTA TTA (trauma team activation) after being found asleep laying on top of a heater for unknown length of time. Noted to have 3rd degree burns (1) burns to R (right) side of face and back of R hand, 2nd (2) degree burns to

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chest and L (left) shoulder. R eye is swollen shut. Estimate 10% TBSA (total burn surface area) affected."

Review of the hospital's admission history and physical dated 1/8/18 documented, "HISTORY OF PRESENT ILLNESS: The patient is a 57-year-old patient at a nursing home who was found over a space heater. He was responsive to questions by blinking. PHYSICAL EXAMINATION: His vital signs on arrival here are blood pressure 106/81(3), heart rate of 140 (4), respiratory rate of 27 (5), O2 (oxygen) sat (saturation) 94% (6) on a non-rebreather (7)...The right pupil is obscured due to significant edema around the right orbit with inability to open the eye. The left pupil is 4 mm (millimeters) and reactive.... The right side of the face has blistering around the orbit and maxilla (8) ...There is a small blister of 2x3 cm (centimeter) along the right lower chest. He has blistering over the right dorsal (9) hand wrapping around to the hypothenar eminence (10) with some surrounding erythema (redness)."

Review of the nurse's notes dated 1/8/18 at 4:20 p.m. documented, "Aide informed nurse to come to room to check on resident because she observed resident lying on heater (R) [right] side of face + (and) hand was on heater noted yellow drainage coming from hand, this nurse came in to room to assess resident called residents (sic) name (no) answer observed (R) side of face + (R) hand swollen + discolored yellow substance appeared to be coming from face. (R) side weak noted leaning to that side resident transferred to bed, cleaned up vs (vital signs) obtained 90/86 (blood pressure) - 116 (pulse) - 18 (respirations) - 104 (temperature). O (sic) [oxygen] - 93% on 2 L (liters) O2 (oxygen) 911 called EMT (emergency

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medical transport) arrived resident to (name of hospital) MD (medical doctor) aware at this time RP (responsible party) notified, prior to incident this AM @ approx (at approximately) 815 AM (8:15 a.m.), this writer observed resident sitting in chair by heater + appeared sleep (sic) @ approx 445 AM (4:45 a.m.) did not appear to be in any distress @ the time, talked (with) RP in regards to residents (sic) condition RP states she is aware that resident has had a decline, states hospital is trying to rule out bleeding of brain and or stroke will keep us updated + will be in town tonight but will go to hospital to see resident in AM."

Review of the PTAC vendor's letter to the facility dated 1/9/18 documented in part, "(Name of vendor company) was asked to check out GE (General Electric) PTAC Model #AZ22EO9D5BM2 in Room 315 (Resident #1's room number). The unit was thoroughly checked out and found to be in good working order to the GE (General Electric) Manufacturer Specifications. (Name of vendor company) is an authorized servicer for Amana PTAC Units, but we also service all other brands of PTAC units."

A facility tour was conducted on 1/10/18 at 1:15 p.m. by five surveyors. Each resident room was entered. During the tour, there were two different types of PTACs observed. An old model unit [model #AZ22EO9D5BM2] with a plastic grill on the front with 1 to 1 and 1/2 inch openings with a wire mesh behind the grill. There were two dials on the unit. The right dial had markings for "High heat, low heat, stop, low fan, high fan, low cool, high cool." The left dial had markings for, "High heat" when the dial was turned all the way to the left and "High cool" when turned all the way to the right. The dials on the PTAC unit were easily

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turned and accessible to residents to adjust temperature settings. The other newer model had a digital display and the plastic grill openings were one inch wide. No portable space heaters were found in any resident rooms.

An observation of Resident #1's room was made on 1/10/18 at 2:45 p.m. with OSM (other staff member) #4, the maintenance technician. There were no other residents in the room. Resident #1's bed was against the left wall. There was a red nylon camping chair sitting in front of the PTAC unit. OSM #4 was asked to turn the PTAC unit onto high heat and to check the PTAC unit's surface temperature. OSM #4 adjusted the unit dial easily to high heat and obtained the temperature with a facility laser radiation thermometer. The door to the resident's room was closed and the temperature was checked. The surface temperature of the unit registered 133 degrees. The resident's room door was opened as was the resident's practice and the surface temperature of the unit was rechecked. The temperature was 133 degrees F. When the surveyor's held the back of their hands to the unit, within 30 seconds it was too hot to keep the hands on the unit. When OSM #4 was asked to check the heat coming from the unit with his hand, OSM #4 did not have a response When asked what the thermostat was set at on the unit, OSM #4 stated, "I would have to look it up." OSM #4 stated the (PTAC) vendor had been in and said that the unit was operating correctly. When asked how many different types of PTAC units the facility had, OSM #4 stated that there were two types and that as the older units (as in Resident #1's room) broke down the newer digital units were put in place. When asked how many of the older units were still in use in resident rooms

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in the facility, OSM #4 stated he thought there were 24 of the old units remaining.

An interview was conducted on 1/10/18 at 2:55 p.m. with OSM #3, the director of maintenance and ASM (administrative staff member) #1, the administrator. When asked how often preventative maintenance was done on the PTAC units, OSM #3 stated, "They're cleaned once a month. We don't physically service them. When they break we replace them." When asked to check the heat on the surface of the unit with their hands and to check the temperature of the wire mesh behind the grill, ASM #1 stated, "Yeah, you can get your hand in the slot there." ASM #1 agreed that the wire mesh was hot to the touch. When asked what the maximum temperature from the unit should be, OSM #3 stated, "We talked to the vendor. He said it should be 120 degrees F." A surface temperature check was then made with the laser radiation thermometer on a digital PTAC unit. The unit was turned to the maximum 90 degrees and allowed to run with the resident room door closed for approximately five minutes. The surface temperature check was 90 degrees. The grill to the unit was warm to the touch. When asked how many of the older units were in the facility, OSM #3 stated there were 37.

A telephone interview was conducted on 1/10/18 at 3:09 p.m. with OSM # 5, the PTAC vendor. OSM #5 stated he had checked the unit in Resident #1's room on 1/9/18. OSM #5 stated the unit was operating correctly and that the temperature coming out of the unit was 123 degrees F when he checked it. When told informed of the units 133-degree F surface temperature obtained by OSM #3 earlier this day, OSM #5 stated, "The laser is picking up heat on

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the surface. The thermostat will shut off at 136 degrees." When asked if a steak would cook on the surface of the PTAC unit with this temperature, OSM #5 stated it would but it would take hours. When asked if skin would burn if it came in contact with the PTAC unit's grill, OSM #5 stated, "I just told you steak would cook."

On 1/10/18 at 3:15 p.m., the facility's investigation for the incident with Resident #1 was requested from ASM #8, Regional Director of Clinical Services. The investigation was received at 3:25 p.m. and included a four-point plan of correction. Review of the 1/8/18 investigation documented in part:
"1/7/2018-10 p.m.-Resident accepted and tolerated medication.
1/8/2018- 2 a.m. - Resident was observed sitting up in chair with eyes closed.
1/8/2018- 3:30 a.m.- Resident was observed sitting up in chair with eyes closed.
1/8/2018- 5:30 a.m. - Resident observed sitting up in chair with eyes close. Resident alert and responsive and accepted medications as indicated.
11(sic)/8/2018- 4:45 a.m.-Resident observed sitting in chair beside heater with eyes closed.
11(sic)/8/2018- 8-8;( sic) 15 am alerted by CNA (certified nursing assistant) #6 to come to room to see about patient.
1/8/2018 8:26 a.m. - RN (registered nurse) asked to assess resident and it is a 911..."

Review of the four-point plan of correction revealed the plan was incomplete and did not mitigate the concern for immediate jeopardy. The four-point plan of correction provided documented, "A complete review has been done on all the PTAC in current resident rooms to

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ensure they are in proper working order. Education has been provided to current residents in the facility on the importance of not being in close proximity of the PTAC when in heat mode." The plan did not address how the PTAC unit's temperatures would be controlled to prevent future burns to other residents. In addition, only twenty-three residents had signed that they had received education.

On 1/10/18 at 4:37 p.m. the supervisors at the Virginia Department of Health, Office of Licensure and Certification (OLC) were contacted regarding Resident #1's second and third degree burns resulting from the older model PTAC unit and the concern for Immediate Jeopardy as a result of older model PTAC units being accessible to residents with temperatures sufficient to cause tissue injury, third and second degree burns. After a discussion, OLC Supervisors agreed with the Immediate Jeopardy assessment.

On 1/10/18 at 4:40 p.m. ASM #1, the administrator, ASM #2 the director of nursing and ASM #8 were made aware of the above concern of Resident #1 having sustained second and third degree burn injuries on an older model PTAC unit, and the concern of older model PTAC units, being accessible to residents with ambient temperatures sufficient to cause tissue injury, resulting in Immediate Jeopardy. ASM #1, ASM #2 and ASM #8 were made aware that the Immediate Jeopardy started on 1/8/18 at 8:25 a.m. when Resident #1 was found unconscious with burns to the face, chest and hands. All agreed that although the unit (in Resident #1's room) had been checked by the PTAC vendor and found to be working correctly the issue was the temperature of the surface of the unit leading

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to the risk of burns to other residents, creating an unsafe environment.

Random PTAC unit checks were conducted on 1/10/18 starting at 4:51 p.m. with OSM #3 and another surveyor. At 4:51 p.m., in Room 328, upon entering room, The PTAC unit heat was on almost all the way on high heat. OSM #3 obtained the ambient air temperature coming from the unit with a facility infrared/laser temperature reader. When asked if the thermometer had been calibrated, OSM stated it had been. The temperature reading was 133 degrees F. The temperature on the unit was turned up all the way. At 4:55 p.m., the temperature reading after 4 minutes on high was fluctuating between 135 and 140 degrees F.

4:57 p.m., in Room 312, the PTAC unit heat was on high upon entering the room. The ambient air temperature coming from the unit was tested by OSM #3 using the facility infrared/laser temperature reader. The temperature reading on the thermometer was fluctuating between 144 and 150 degrees F.

5:07 p.m., in Room 308, upon entering the room, the PTAC heat was turned off. OSM #3, the maintenance director turned the heat up to high at 5:08 pm. At 5:10 p.m., the ambient air temperature coming from the unit was tested by OSM #3 using the infrared/laser temperature reader. The temperature reading was 146 degrees F.

5:11 p.m., in Room 309, upon entering the room, the PTAC heat was running on high. The ambient air temperature coming from the unit was tested by OSM #3 with the facility infrared/laser

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temperature reader. The temperature was 165 degrees F.

5:15 p.m., in Room 305, upon entering the room, the PTAC heating unit was off, OSM #3 the maintenance director, was not able to get the unit to turn on. The PTAC unit was not functioning.

5:19 p.m., in Room 301, upon entering the room, the PTAC unit was off., OSM #3 the maintenance director, turned the PTAC heat to high. At 5:22 p.m., OSM #3 tested the ambient air temperature coming from the unit with the facility infrared/laser temperature reader. The temperature was 150 degrees F.

5:26 p.m., in Room 226, upon entering the room, the PTAC unit was off., OSM #3 the maintenance director, turned the PTAC heat to high at 5:27 p.m. At 5:31 p.m., OSM #3 tested the ambient air temperature coming from the unit with the facility infrared/laser temperature reader. The temperature was 132 degrees F.

5:32 p.m., in Room 236, on entering the room the PTAC unit was running on low fan, no heat. Ambient air temperature coming from the unit was tested by OSM #3 with the facility infrared/laser temperature reader. The temperature was 73 degrees F. OSM #3 turned the heat to high at 5:32 p.m. At 5:35 p.m., the temperature reading was 118 degrees F. At 5:36 p.m., the temperature reading was 130 degrees F.

An additional observation was made of Resident #1's unit with another surveyor on 1/10/18 at approximately 5:15 p.m. The red nylon camper

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chair was measured to be 14 and 1/2 inches off the floor. The seat of the chair came up to the bottom of the grill on the unit. When Resident #1 was sitting in the chair next to the heater and when he slumped over, his cheek would be directly over the grill. The grill on the PTAC unit was observed to contain four fixed sections ranging from one to one and one half inches wide. There was a dried yellow substance on the left lower grill of the unit. The surveyors were able to touch the wire mesh with their fingertips through the grill. The unit was placed on high heat and high fan settings. The surveyors could not hold the back of their hands to the unit for longer than 30 seconds before the unit was too hot to touch.

An interview was conducted on 1/10/18 at 5:30 p.m. with CNA (certified nursing assistant) #9, an aide who worked with Resident #1. CNA #9 was asked to enter Resident #1's room and to touch the unit's grill and the wire mesh. CNA #9 stated, "Yeah, it's hot." When asked what room temperature the resident liked, CNA #9 stated, "The (Resident #1 and the roommate) loved to keep it warm. It's actually a little cooler than normal."

On 1/10/18 at 8:45 p.m., a request was made from ASM #1 to have the surveyors come to Resident #1's room. ASM #1, the administrator, ASM #2, the director of nursing, ASM #8, the regional director of clinical services, ASM #7, the corporate director of nursing services, ASM #6, the regional director of maintenance, OSM #3, the director of maintenance and OSM #5, the PTAC vendor were all present. ASM #6, the corporate director of maintenance stated, "We've

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adjusted the temperature so the residents can't put it on high." OSM #5, the PTAC vendor stated, "That laser thermometer must have measured the element temperature." OSM #5 was asked to measure the unit's surface temperature with his equipment. The temperature registered at 136 degrees F. When asked what the room temperature was, OSM #5 stated, "About 90 degrees." When asked when the heater would turn off OSM #5 stated, "It'll turn off when the room gets to temperature but with the door open it's going to keep running." OSM #5 asked OSM #3 if the laser thermometer had been calibrated, OSM #3 stated yes. When asked if the surface temperature of the unit would remain as hot, OSM #5 stated, "The internal coil will shut down at 136 degrees." All present were asked to check the unit's grill. ASM #1 and ASM #8 and two surveyors all agreed that the unit felt hot to the touch. OSM #5 then lowered the unit's temperature again by placing a metal peg under the temperature dial preventing the dial from being turned to the high heat setting. OSM #5 stated, "It's set for 72 to 74 degrees." A recheck of the unit's surface temperature by OSM #5, three minutes later showed the temperature to range between 77.4 degrees to 104 degrees F.

On 1/10/18 at 9:51 p.m., ASM #1 provided a four-point plan of correction that documented the following:
1. "Resident found slumped over PTAC unit at approximately 8:25 am. The Resident was provided treatment and sent to the ER (emergency room) for further evaluation and treatment. The PTAC unit was locked out and tagged out and place out of use pending an outside vendor's inspection. The resident's roommate was voluntarily moved to another room

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pending PTAC's inspection.
2. A quality review of identified PTAC Units in resident rooms completed by a certified outside vendor on 1/10/18. Identified PTAC units mechanical thermostat stop adjusted to the lowest position in order to prevent the thermostat from allowing the air to rise to a higher unsafe temperature ensuring resident's safety.
3. Education provided to the Maintenance Director, IDT (interdisciplinary team) and facility staff on the importance of ensuring resident safety while in PTAC is in use in heat mode and maintaining the mechanical thermostat in the lowest position in order to prevent the air from rising to a higher unsafe temperature. Education provided to the residents in the facility on the risks of injury when using the PTAC system while in heat mode. During the months of January, February, and March residents to be re-educated at Resident Council of risks of injury when using PTAC units in heat mode.
4. The Maintenance Director/designee to complete quality monitoring 5 times a week for 4 week, weekly x4 weeks then monthly and PRN (as needed) to ensure PTAC units mechanical thermostat stop adjusted to the lowest position in order to prevent the air from rising to a higher unsafe temperature ensuring residents safety. Quality monitoring schedule to be modified based on findings.
-Results to be discussed during QAPI (quality assessment plan and improvement).
-Completion date: 1/10/2018."

On 1/11/18 at 8:15 a.m., a repeat request for the PTAC unit manufacturer's manual to was made to ASM #1, the administrator.

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On 1/11/18 at 8:30 a.m., the manufacturer's manual was received. Review of the manual did not document information regarding the surface temperature of the unit.

An interview was conducted on 1/11/18 at 8:48 a.m. with CNA (certified nursing assistant) #6, Resident #1's aide on 1/8/18. When asked what routine staff follow when they come on duty, CNA #6 stated, "I get report and I go walk down the hall. I visualize the residents and start my day." When asked what occurred on 1/8/18, CNA #6 stated, "I visualized (name of Resident #1) sitting by the heater (PTAC) but that's normal for him. That was about seven-ish." When asked Resident #1's position in the chair, CNA #6 stated, "He was slumped over with his right arm across the chair arm touching the floor by the heater." When asked if that was an unusual position for Resident #1, CNA #6 stated, "No. It wasn't unusual to see him in all sorts of unusual positions. Sometimes he slept with his head off the side of the bed or he'd sleep on the floor." When asked if Resident #1 was resting his head on the heater, CNA #6 stated, "I couldn't tell that his face was on the heater. I thought he was asleep because when I brought his breakfast in I said, '(Name of Resident #1) you have to eat your cheerios and drink your coffee' and when I straightened him up that's when I saw his hand and face." When asked what time the breakfast was brought in, CNA #6 stated, "Around 8:15 (a.m.)." When asked what she saw, CNA #6 stated, "I see this gigantic blister on his hand." When asked about Resident #1's face, CNA #6 stated, "At that point I didn't (see his face) because I'm standing behind him in the chair." When asked what she did next, CNA #6 stated, "I flew out, went, and got the nurse. I told the nurse

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'you got to see (name of Resident #1) he's got a blister on his hand. It's the size of a grapefruit.'" When asked what happened after next, CNA #6 stated, "The nurse came in. We straightened him up and then we saw the right side of his face was swollen and there was dried yellow substance along the side of his face and mouth and nose." When asked if Resident #1 was responsive, CNA #6 stated, "He was sorta kinda unresponsive." When asked about the temperature in the room, CNA #6 stated, "He loved that room boiling hot." When asked if she had ever touched the heater in the room, CNA #6 stated, "No. I didn't think they'd get that hot to burn." When asked if she had received any education since the incident, CNA #6 stated, "We had an in-service on rounding. Make sure you do your rounds and it may have been prevented if someone had done their rounds. Keep the residents and their belongings off the heaters."

On 1/11/18 at 9:08 a.m., a tour of the facility was conducted with the OSM #3, the director of maintenance. Each of the 37 rooms that was utilizing the old PTAC heating unit was checked. For each room, upon entering, if the unit was off, the OSM #3 turned it on. Then a period of 1 to 2 minutes was allowed to pass and then the temperature was checked by OSM #3. If the unit was already on and running upon entering the room per resident preference, the temperature was checked immediately. The ambient temperatures of the air coming from the PTAC unit was obtained with the same infrared laser temperature reader previously used. The temperature range of PTAC units was 63 degrees to 157 degrees F, depending on if the unit had already been running and was up to temperature, or had to be turned on from cold. In every case,

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the PTAC units turned off automatically after the unit ran for approximately 1 to 3 minutes. The surface temperature of the PTAC units did not get too hot to touch at any time.

An interview was conducted with two residents on 1/11/18 between 9:40 a.m. and 9:45 a.m. When asked if they had received education regarding the heaters under the windows in their rooms in the past few days, both residents stated they had not had any education, though their names were listed on the education sign off sheet. The one resident stated, "no, I am blind." When asked if they had spoken to him about his heating unit, the resident emphatically stated, "No." Both resident had a BIMS (brief interview for mental status) score of 15 indicating they were cognitively intact to make daily decisions.

On 1/11/18 at 10:15 p.m., a telephone conversation was held with OLC supervisor. The supervisor was updated regarding the facility staff education and that there was no definition of which residents were to be educated. A decision was made to have the facility update the plan of corrections at that time.

On 1/11/18 at 10:25 a.m., ASM #1 and ASM #7 were made aware of the need to clearly state when facility staff would be educated and which residents were appropriate to be educated. ASM #1 and ASM #7 were made aware that two residents who had signed the education form that they had been educated about the PTAC units, stated they were not educated.

An interview was conducted on 1/11/18 at approximately 9:45 a.m. with RN (registered nurse) #1, Resident #1's nurse on 1/8/18. When

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asked what had occurred on 1/8/18, RN #1 stated she was the night shift supervisor that night. RN #1 stated, "I went in there and I seen him (Resident #1) sitting in his chair with his head down towards his chest and his arms were on the arms of the chair." When asked what time that was, RN #1 stated, "That was about 4:45-ish (a.m.)." When asked if there was anything unusual about Resident #1 at that time, RN #1 stated, "No ma'am, not at all. He always liked to be in the heat and he liked to sit next to the heater." When asked what happened then, RN #1 stated, "The aide called me into the room. She said she gave him (Resident #1) his tray and that when he was sat up he was not responding." When asked what she did next, RN #1 stated she had gone into the room and that she noted a yellow substance on the resident's face and hand and that substance was on the heater. When asked what she thought the yellow substance was from, RN #1 stated, "I think it was fluid from his skin. It didn't seem like it was coming from his mouth." When asked how she thought Resident #1 sustained the blister to his hand, RN #1 stated she did not know. When asked how Resident #1 looked, RN #1 stated, "it looked like he might have had a stroke because he was weak on that (the right) side." When asked if she was his nurse at the time the aide came to get her, RN #1 stated she was. When asked if she had seen Resident #1 since 4:45 a.m. RN #1 stated she had not. When asked what information she received in report about the resident that day, RN #1 stated, "I hadn't seen him for about a year. They told me he was himself and he was sleeping in the chair."

An interview was conducted on 1/11/18 at 10:30 a.m. with LPN (licensed practical nurse) #4, the

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resident's night nurse. When asked what routine staff follow when they arrive on duty, LPN #4 stated, "I started my shift about 5:30 (p.m.) to six o'clock. I counted out my cart (checked the medications) and I made rounds on all my residents." When asked when she had seen Resident #1 on her shift, LPN #4 stated, "I saw (name of Resident #1) a couple times." When asked what the resident was doing, LPN #4 stated, "At nine p.m. he was sitting straight up (in the chair) with his arms folded. His baseline at night is that he's up and down. He never sleeps." When asked when was the last time she saw Resident #1 prior to going home, LPN #4 stated, "It was around 5:30 (a.m.) I was just passing the room. I said 'Hey (name of Resident #1) you want to go to bed? He said, no leave me alone'." When asked where Resident #1 was at that time, LPN #4 stated he was sitting in his chair next to the heater. LPN #4 was asked what staff should do if they notice a resident slumped over in a chair. LPN #4 stated, "I've been a nurse for 14 years. Common sense would be if you saw him slumped over on the radiator I would reposition him." When asked if she was aware that the PTAC units got hot to touch, LPN #4 stated, "No ma'am. I've never touched them at all." When asked if she had received any education since the incident, LPN #4 stated, "My education was to make sure patients aren't sitting too close to the radiators. Ask them to move. Make sure there are no cups or anything on the radiator."

An interview was conducted on 1/11/18 at 11:40 a.m. with RN #3, the assistant director of nursing. When asked the routine nurses follow when coming onto their shift, RN #3 stated, "They make sure staffing is appropriate and have them lay eyes on the patients. Make contact. Get report

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then they make a quick round. Then they come back and get their (medication) cart." When asked the routine CNAs follow when coming onto their shift, RN #3 stated, "They don't have to wait for their assignment to check on the residents." When asked how often residents were checked, RN #3 stated, "Every two hours either by the nurse or the CNA." When asked what staff should do if they see a resident in a slumped position, RN #3 stated, "I would expect them to kinda touch him to make sure he roused up. Find out what's going on." When asked what occurred on 1/8/18 at 8:25 a.m., RN #3 stated, "I came in, he (Resident #1) was like this (RN #3 demonstrated by turning her face down and to the right) and his (right) hand was on his leg. I wasn't sure what was going on." When asked what Resident #1's right hand looked like, RN #3 stated, "It had a large blister." RN #3 held her hand approximately 4 to 5 inches from the top of her hand to show the size of the blister. When asked how Resident #1 received the blister to his hand, RN #3 stated she did not know. RN #3 stated, "His face had blisters that were opening." We checked his vital signs and got him on the bed to further assess what was going on. EMS (emergency medical services) got here really fast and they took over." When asked how Resident #1 sustained a burn to the left chest and shoulder, RN #3 stated she did not know and had not seen it. When asked how Resident #1's temperature was taken, RN #3 stated it was an axillary temperature (under the armpit) on the left side. RN #3 stated, "It was 103 point something and it was going up." When asked if Resident #1 was responsive, RN #3 stated, "He was moaning." When asked if the resident kept the door to his room open or closed, RN #3 stated Resident #1 kept the door open. When asked if the room was hot when she went

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in, RN #3 stated it was. When asked if she knew the PTAC heaters got hot to the touch, RN #3 stated, "No I didn't know how hot they got."

An interview was conducted on 1/11/18 at 10:50 a.m. with ASM #2, the director of nursing. When asked what the CNA's routine was when they arrived on duty, ASM #2 stated, "My expectation is that they should round. They should get report. Answer any lights and attend to any patient needs at that moment." When asked what the nurse's routine was, ASM #2 stated, "They should receive report. They are responsible that the CNA's are where they are supposed to be." When asked what occurred on 1/8/18 with Resident #1, ASM #2 stated, "At 8:25, 8:26 (a.m.) I heard the stat (immediate) page. When I ran down there (RN #3 and CNA #6) were already preparing him (Resident #1) for transfer (to the hospital)." When asked how the resident looked, ASM #2 stated, "His right eye was kinda closed and here (ASM #2 indicated the area around the right eye and right cheek) was blistered. I was thinking he had a seizure. He had yellow substance on here (indicating the right cheek). It was crystallized. When we called the hospital they thought it was coming from his mouth which also led us to believe that he had a possible aspiration (11) if he had had a seizure." When asked if a resident was slumped over should the staff assess them, ASM #2 stated, "Absolutely." When asked about the education provided to the staff, ASM #2 stated, "My thought process was making sure we're rounding. Like my mother said, 'every eye closed doesn't mean you're asleep'. Staff are checking on the residents. We also started educating the residents. I want them to be aware of the risk of being too close (to the heater). We tried to pin point (residents) who really like their room really

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hot because I know (name of Resident #1) did."

On 1/11/18 at 11:12 a.m., an updated plan of correction was received. The changes to the plan were as follows: 3)...Facility staff to receive education prior to accepting an assignment and/or to be removed from the schedule until education is provided. Education provided to current residents who are ambulatory and have a BIMS of 13 - 15 on the risks of injury when using the PTAC system while in heat mode and the rational for maintaining the mechanical thermostat stop in the lowest position to prevent the air temperature from rising to a higher unsafe temperature ensuring resident's safety. Resident who are non-ambulatory and/or unable to be educated with a BIMS less than 13 to have safety checks regarding PTAC/Air temp twice daily utilizing mock survey rounds."

A telephone interview was conducted on 1/11/18 at 2:15 p.m. with ASM #4, the wound care physician. When asked how long it would take for a resident to sustain a third degree burn when lying on a surface with a temperature of around 130 degrees F, ASM #4 stated, "Under 15 minutes. It's quick if it's hot on the back of our hand." ASM #4 stated that he had seen people get a third degree burn from the beanbag heating pads put in the microwave for 30 seconds. ASM #4 was asked why Resident #1 would have a temperature of 104 degrees, ASM #4 stated, "He probably put himself by the radiator."

A telephone interview was conducted on 1/11/18 at 2:20 p.m., with ASM #5, Resident #1's physician. When asked if there had been any recent changes in the resident, ASM #5 stated there was not. When asked what he thought

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happened to Resident #1 on 1/8/18, ASM #5 stated, "They (the physicians at the hospital) think it may have been a seizure. He was weaned off the Keppra (12) by the neurologist in November. He had to be unconscious (to not move away from the heat). This just happened out of the blue."

An interview was conducted on 1/11/18 at 2:45 p.m. with ASM #1, the administrator. When asked what occurred on 1/8/18 with Resident #1, ASM #1 stated, "I got a call at 8:27 a.m. I couldn't pick it up because I was getting blood work. I got a call 3 minutes later. They told me about (name of Resident #1) with the blister on his hand and a large blister on his face. I got here. I called my boss and told her I need someone here today. I told her I needed to address this today. This was a learning opportunity (the immediate Jeopardy). You just can't tell staff and residents to keep things away from the heater. I wasn't thinking to stop the heater from getting so hot (to touch)."

Throughout the day on 1/11/18 multiple facility staff were interviewed regarding education. All staff could verbalize education regarding patient safety in regards to the PTAC units and the importance of rounding and assessing residents every two hours.

On 1/11/18 at 3:35 p.m., interviews were conducted with one LPN (licensed practical nurse) and one CNA from each of the three units from the 3:00 p.m. to 11:00 p.m. shift. All staff could verbalize education they received regarding patient safety in regards to the PTAC units and the importance of round and assessing residents every two hours.

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On 1/11/18 at 3:40 p.m., interviews were conducted with one resident from each of the three units regarding PTAC unit education. All the residents had a BIMS of 15 and were able to verbalize education regarding safety and the PTAC units.

On 1/11/18 at 4:03 p.m., an interview was conducted with OSM #3, the director of maintenance. When asked if he had received education regarding the PTAC units, OSM #3 stated, "We got educated on how to adjust the PTAC so it (the temperature) doesn't get too high."

On 1/11/18 at 4:08 p.m., the Immediate Jeopardy was abated. ASM #1 was notified of the abatement at that time.

No further information was provided prior to exit.

COMPLAINT DEFICIENCY

1. Third degree burn -- Third-degree burns occur when the epidermis is lost with damage to the subcutaneous tissue. Burn victims will exhibit charring and extreme damage of the epidermis, and sometimes hard eschar will be present. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2935806/

2. Second degree burn -- Second-degree burns manifest as erythema with superficial blistering of the skin, involving the superficial (papillary) dermis and may also involve the deep (reticular)

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dermis layer. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2935806/

3. Blood pressure -- Normal blood pressure for adults is defined as a systolic pressure below 120 mmHg and a diastolic pressure below 80 mmHg. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/high-blood-pressure

4. Pulse -- he usual resting pulse for an adult is 60 to 100 beats per minutes. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024325/

5. Respiratory rate -- The best alternative in a normal individual would be to choose an intermediate rate of 10 to 20 breaths per minute. This information was obtained from: https://www.ncbi.nlm.nih.gov/books/NBK365/

6. Oxygen saturation -- a device that measures the oxygen saturation of arterial blood in a subject by utilizing a sensor attached typically to a finger, toe, or ear to determine the percentage of oxyhemoglobin in blood pulsating through a network of capillaries. This information was obtained from: https://www.merriam-webster.com/dictionary/pulse%20oximeter

7. Non-rebreather mask -- an apparatus with face mask and gas supply forming a closed system from which one can breathe as long as the concentrations of oxygen and carbon dioxide remain within tolerable limits. This information was obtained from:

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https://www.merriam-webster.com/dictionary/rebreathers

8. Maxilla -- An upper jaw especially of humans and other mammals in which the bony elements are closely fused. This information was obtained from:
https://www.merriam-webster.com/dictionary/maxilla

9. Dorsal -- the back of the hand; surface of hand opposite the palm. This information was obtained from:
http://www.medilexicon.com/dictionary/26488

10. Hypothenar eminence -- An abnormality of the hypothenar eminence, i.e., of the muscles on the ulnar side of the palm of the hand (i.e., on the side of the little finger). This information was obtained from:
https://www.ncbi.nlm.nih.gov/medgen/869380

11. Aspiration -- Aspiration of oropharyngeal or gastric contents into the lower respiratory tract is a common event in critically ill patients, and can lead to pneumonia or pneumonitis. Aspiration pneumonia is the leading cause of pneumonia in the intensive care unit and is one of the leading risk factors for acute lung injury and acute respiratory distress syndromes. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3102154/

12. Keppra -- KEPPRA is indicated as adjunctive therapy in the treatment of partial onset seizures in adults and children 1 month of age and older with epilepsy. This information was obtained from:

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3ca9df05-a506-4ec8-a4fe-320f1219ab21

2. The facility staff failed to ensure a safe environment for Resident #3 including even floors as per the comprehensive care plan to prevent falls. Multiple observations of Resident #3's room revealed an entire 12-inch by 12-inch floor tile missing in the middle of the room.

Resident #3 was admitted to the facility on 7/10/15 with the diagnoses of but not limited to chronic kidney disease, high blood pressure, Alzheimer's Disease, diabetes, and psychosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/17/17. Resident #3 was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 1 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring total care for bathing; extensive care for bed mobility, dressing, toileting, and hygiene; Supervision to limited assistance for ambulation; and as frequently incontinent of bowel and bladder.

On 1/10/18 at 2:30 p.m., 5:11 p.m., 6:10 p.m., and 7:35 p.m.; and on 1/11/17 at 8:30 a.m., Resident #3's room was observed. During each observation an entire 12 inch by 12-inch floor tile was observed missing in the middle of the room.

On 1/11/18 at 8:25 a.m., in an interview with CNA #2 (Certified Nursing Assistant) she stated the resident is ambulatory without the use of a walking assuasive device. When asked about the missing floor tile, CNA #2 stated she was not aware it was missing. When asked if the missing

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tile would cause a tripping hazard for the resident, CNA #2stated it would. When asked if she ever looks at the resident's care plan, CNA #2 stated no. When informed Resident #3's comprehensive care plan documented the resident should have an even floor surface for safety, and asked if the care plan being followed, CNA #2, stated, "No."

On 1/11/18 at 8:30 a.m., in an interview with LPN #1 (Licensed Practical Nurse) she stated that the resident is an ambulatory resident. When asked about the missing floor tile, LPN #1 stated she was not aware of it. When asked if this would be a tripping hazard for the resident, LPN #1 stated yes it would be. When asked if she ever looks at the resident's care plan, LPN #1 stated no. When informed Resident #3's comprehensive care plan documented the resident should have an even floor surface for safety, and asked if the care plan being followed, LPN #1, stated, "No."

On 1/11/18 at 8:38 a.m., in an interview with OSM #3 (Other Staff Member - the Director of Maintenance) he stated that the missing tile would be a tripping hazard for the resident. OSM #3 stated that maintenance does a daily round to identify these concerns and it had not been noticed. He stated that the nursing and aid staff should also be documenting any issues in resident's rooms in the maintenance log. When informed that he was in the room with the surveyor on 1/10/18 at 5:11 p.m., to check the heating unit, and asked if he noticed the missing 12-inch by 12-inch tile that he walked past/over to get to the heating unit, OSM #3 stated that he did not.

A review of the maintenance log failed to reveal

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any concerns having been identified with Resident #3's room as requiring any maintenance repair needs.

A review of the facility policy, "Maintenance Log" documented that the logs should be completed immediately upon performing the work. The policy did not document any guidance for nursing staff and aid staff to complete a request or notification of needed repairs identified in the residents' rooms.

A review of the facility policy, "Cleaning Procedures" documented, "2. Discharge Cleaning of a Resident's Room...W. Any maintenance problems such as frayed wire, broken plugs or beds not working should be reported to maintenance via the maintenance log." The policy did not address reporting of maintenance concerns identified during routine daily cleaning while the resident was still residing in the room.

On 1/11/18 at 5:33 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to ensure a safe environment in the resident's bathroom for one of six residents in the survey sample, Resident #5. Resident #5's bathroom was observed with broken and missing tiles. The broken tiles had sharp pointed edges and some tiles were pushed into the wall.

Resident #5 was admitted to the facility on 6/26/12 with a recent readmission on 3/15/17 with diagnoses that included but were not limited to:

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multiple sclerosis [MS] (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover, it progresses slowly with increasing disability (1)), muscle weakness, paraplegia (paralysis of the lower limbs (2)), high blood pressure, depression, dysfunction of the bladder, and absence of toe.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/21/17 coded Resident #5 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he is cognitively intact to make daily decisions. The resident was coded as being independent in transfers, moving on and off the unit, and eating. He was coded as requiring limited assistance for moving in the bed and walking in the corridor and extensive assistance of one or more staff members for his toileting needs and his personal hygiene. In Section G0400 - Functional Limitation in Range of Motion, the resident was coded as having no impairment in either his upper or lower extremities. In Section G0300 Balance During Transitions and Walking, Resident #5 was coded as being unsteady but able to stabilize without staff assistance in moving from seated to standing position, walking, turning around and facility the opposite direction while walking and surface-to-surface transfers.

Observation was made during the initial tour on 1/10/18 at 1:30 p.m. of Resident #5's bathroom. There were broken tiles on the lower part of the bathroom wall. There were missing tiles and tiles broken with sharp pointed edges and tile pushed into the wall.

An interview was conducted with Resident #5 on

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1/10/18 at 6:58 p.m. When asked if he walks in the bathroom, Resident #5 stated that he sometimes walked in the bathroom. When asked if he uses his hand crutches to ambulate into the bathroom, Resident #5 acknowledged that he indeed did ambulate with his hand crutches into the bathroom. The wall in the bathroom was again observed. There was an area 26 inches wide by eight inches high, with five broken tiles, several with sharp edges, nine loose tiles and an open area of missing tiles measuring 8.5 inches by three inches.

On 1/11/18 at 8:36 a.m. an interview was conducted with other staff member (OSM) #3, the director of maintenance. When asked about the process for the staff to report things in need of repair, OSM #3 stated, "There are muck surveys done every morning by the administrative team. The nurse or CNA (certified nursing assistant) or whoever sees it should log it in the maintenance log book at each nurse's station."

On 1/11/18 at 8:40 a.m. the maintenance logs, for the unit on which Resident #5 resided, were reviewed. There was no documentation regarding the broken, missing or loose tiles in Resident #5's bathroom documented.

On 1/11/18 at 10:45 a.m. an interview was conducted with Resident #5. When asked how long the tiles on the bathroom wall have been broken, Resident #5 stated, "A long time." When clarified that it didn't happen yesterday, Resident #5 stated, "Oh no, it's been there for a little while now."

On 1/11/18 at 10:50 a.m. an interview was conducted with CNA #12. When asked what she

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does when she finds something broken in a resident's room or a resident area, CNA #12 stated, "I let the charge nurse know. Or I go find them (maintenance staff) in their office. I can call over the loud speaker." When asked if there was a book she could write her concern in, CNA #12 stated, "No, but I can leave a note at the nurse's station too."

An interview was conducted with LPN (licensed practical nurse) #5, on 1/11/18 at 10:54 a.m. When asked how she reports when she observes something that is in need of repair, LPN #5 stated, "I can call or page (maintenance) to the floor. I can notify my supervisor or put it in the maintenance book."

On 1/11/18 at 11:34 a.m. OSM #3, the director of maintenance and administrative staff member (ASM) # 6, the regional director of maintenance, were shown Resident #5's bathroom. When asked if he was aware of the broken, missing and loose tiles, OSM #3 stated, "No, (Resident #5) must have run his wheelchair into it." ASM #6 stated, "This should have been picked up on during morning survey rounds."

Resident #5's comprehensive care plan dated 1/11/17, documented in part, "Focus: (Resident #5) has the potential for injury r/t (related to) AEB (as evidenced by) decreased mobility, allergy, deconditioning, diagnosis (impaired vision and hearing), disease process (MS, spasms, incontinence)." The "Interventions" documented in part, "Ensure that the resident is wearing appropriate footwear when ambulating. Maintain a clear pathway, free of obstacles."

The administrator, director of nursing and the

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| F 689 | Continued From page 81<br>regional director of clinical services were made aware of the above concern on 1/11/18 at 5:32 p.m.<br><br>Resident #5 was observed walking in the hallway with his hand crutches with the restorative aide on 1/16/18 at 10:00 a.m.<br><br>No further information was provided prior to exit.<br><br>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.<br>(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 434. | F 689 | | |
| F 729 SS=K | Nurse Aide Registry Verification, Retraining<br>CFR(s): 483.35(d)(4)-(6)<br><br>§483.35(d)(4) Registry verification.<br>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless-<br>(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or<br>(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry.<br>Facilities must follow up to ensure that such an individual actually becomes registered.<br><br>§483.35(d)(5) Multi-State registry verification.<br>Before allowing an individual to serve as a nurse | F 729 | | |

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the immediate jeopardy was abated and the deficiency was assigned a level II pattern.

The findings include:

On 1/10/18 at 1:15 p.m. surveyors entered the facility to investigate a two-day complaint. During the course of investigation an immediate jeopardy was called and a substandard review and expanded survey was initiated.

Part of the substandard review is to ensure all currently employed CNAs (certified nursing assistants) have registry verification of their certifications. A list of currently employed CNAs was requested on 1/10/18 at approximately 5:30 p.m. with their employee file.

On 1/11/18 at approximately 9:00 a.m., review of the CNA employee files was conducted. Less than 50 percent of the 79 currently employed CNAs had an up-to-date certification in their employee file.

On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the human resources director. When asked who was responsible for verifying certifications, OSM #2 stated she verified certifications. When asked about the process followed for verifying certifications, OSM #2 stated when a future employee fills out an application, she will decide from the application if they are a good fit for the company. She will then have the applicant come into the facility to introduce them to the DON (Director of Nursing). OSM #2 stated she will then run a background check and if the background check comes out clean, she will run their certification. When asked if there were any

3. HRC re-educated by the ED/DON/designee regarding ensuring CNA certification verification is current, pending violation documents reviewed/addressed as applicable and validated by the ED/DON per regulation prior to accepting an assignment per regulation.
HRC re-educated by the ED/DON/designee regarding new CNA applicant's certification verification to be reviewed, pending violation documents reviewed/addressed as applicable and validated by the ED/DON per regulation upon hire and prior to extending an offer of employment per regulation.
HRC re-educated by the ED/DON/designee regarding ensuring criminal background checks/Virginia State Police is obtained, placed in the employee file and validated by ED/DON within 30 days of hire per regulation.
HRC re-educated by the ED/DON/Designee regarding CNAs whose certification is due to expire within the month are to be provided a letter requiring signature communicating certification renewal due date with documentation in the employee file. CNA's without proof of current certification to be removed form the schedule until proof of current certification is provided and validated by the ED/DON with documentation in the employee file. ED/DON to be provided a list monthly with identified CNAs.
Human Resources re-educated by the ED/DON/designee regarding responsibility for maintaining the appropriate documentation in the CNA employee file and providing a copy of the Quality Monitor monthly to the DON and ED.

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aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.

§483.35(d)(6) Required retraining.
If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined the facility staff failed to verify the certifications of seventeen out of 79 currently employed CNA's (certified nursing assistant) that been providing direct care to residents. CNA #3, CNA #5, CNA #7 and CNA #19 through 32.

The facility staff failed to obtain certification verification of seventeen currently employed CNAs (certified nursing assistants) CNA #3, CNA #5, CNA #7 and CNA #19 through 32, that been providing direct care to residents. Review of the as-worked schedule from the past two weeks prior to entrance, revealed the 17 CNAs identified had been directly working with residents and providing care, and the facility staff failed to verify CNA #3's certification prior to hire on 9/19/17, who was found to have a pending violation on her certification. This resulted in the identification of immediate jeopardy at a pattern. After a plan of correction was presented, verified and accepted,

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F729: Nurse Aide: Registry Verification, Retraining

1. Identified Certified Nursing Assistant (C.N.A)'s certification verification obtained and placed in the employee file 1/11/18. Identified CNAs pending violation documents obtained, validated/addressed and placed in the employee file 1/11/18. Identified C.N.A's criminal background checks/Virginia State Police obtained and placed in the employee file 1/11/18.

2. A quality review of current CNA employee files by the Human Resources Coordinator (HRC) completed to ensure CNA certification verification is current, pending violation documents obtained and addressed as applicable and validated by Executive Director (ED)/Director of Nursing Services (DON) with documentation in the employee file per regulation. CNA's without a current certification and/or pending violations to be removed from the schedule until certification and/or pending violation documents obtained and validated by the ED/DON with documentation in the employee file per regulation prior to accepting an assignment. Follow up based on findings.
A quality review of current CNA employee files by the HRC completed to ensure criminal background checks/Virginia State Police is current, and validated by ED/DON with documentation in the employee file within 30 days of hire. CNAs without a current criminal background check to be removed from the schedule until a background check is obtained, and validated by the ED/DON with documentation in the employee file prior to accepting an assignment. Follow up based on findings.

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| F 729 | Continued From page 84<br>other times she would verify certifications, OSM #2 stated she has a computer system (payroll program) that alerts her when an employee's certification needs to be verified. When asked why certifications need to be verified, OSM #2 stated certifications need to be verified to ensure that certifications are not expired and to ensure there are no violations against the certification. When asked where certifications should be filed, OSM #2 stated certifications should be filed in the employee's file. OSM #2 stated she would try to find additional certifications.<br><br>On 1/11/18 at approximately 3:00 p.m., OSM #2 handed this writer a stack of certifications that were verified on 9/10/17. OSM #2 stated that she had realized that some CNAs had expired certifications in their employee file and she had printed out current certifications from the department of health professions website. OSM #2 stated that if a current certification was not in the employee file or in the stack of paper just given to this writer, then she did not have them.<br><br>On 1/11/18 at approximately 3:00 p.m., review of the stack of CNA certifications was conducted. Seventeen out of the 79 currently employed CNAs did not have their certification verified. Seventeen out of the 79 current CNAs had expired certifications in their employee file. The CNAs included CNA #3, CNA #5, CNA #7 and CNA #19 through 32. Review of the as-worked schedule from the past two weeks prior to entrance, revealed that the 17 CNAs identified had been directly working with residents and providing care.<br><br>On 1/11/18 at 3:13 p.m., The Office of Licensure and Certification long term care division director | F 729 | 4. HRC/Designee to conduct random quality monitoring of C.N.A employee files to ensure certification verification is current, located in the employee and validated by the ED/DON upon hire per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.<br>HRC/Designee to conduct random quality monitoring of C.N.A employee files to ensure new CNA applicant's certification verification reviewed and validated by the ED/DON upon hire and prior to extending an offer of employment per regulation weekly x 4 weeks, twice monthly x 4 weeks, then monthly, PRN and as indicated.<br>HRC/Designee to conduct random quality monitoring of C.N.A employee files to ensure criminal background checks/Virginia State Police is obtained, placed in the employee file and validated by ED/DON within 30 days of hire per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated<br>HRC/designee to conduct random quality monitoring regarding CNAs whose certification is due for renewal within the month are to be provided a letter requiring signature communicating certification renewal due date with documentation in the employee per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.<br>HRC/designee to conduct random quality monitoring of employee files regarding CNA's without proof of current certification to be removed form the schedule until proof of current certification is provided and validated by the ED/DON with documentation in the employee file per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN and as indicated.<br>Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.<br><br>5. Date of Compliance 3-2-18. | |

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was notified of the above findings and concerns. The supervisor confirmed that the facility was in a second immediate jeopardy.

On 1/11/18 at 3:27 p.m., the facility staff (Administrator and DON (Director of Nursing) were notified that the facility was in a second immediate jeopardy starting on 1/11/18 at 3:13 p.m.

The facility staff presented a POC (plan of correction) on 1/11/18 at 4:00 p.m. The plan documented the following:

1. Identified C.N.A's certification obtained and placed in the employee file 1/11/18. Identified C.N.A's without a current certification removed from the schedule.
2. A quality review of current CNA employee files completed by the Human Resources Coordinator (HRC) to ensure certifications are current and located in the file. CNA's without a current certification to be removed from schedule until a certification is obtained, validated, and placed in their employee file prior to accepting an assignment.
3. HRC re-educated by the Executive director (ED), to ensure C.N.A.'s certifications are current and located in the employee file prior to accepting an assignment. HRC re-educated by the ED to ensure CNAs without a current certification are removed from the schedule until a certification is obtained, validated and placed in their employee file prior to accepting an assignment.
4. HRC/Designee to conduct random quality monitoring of C.N.A employee files 5 times a week for 4 weeks, weekly x 4 weeks then monthly and PRN. Findings to be reported to QAPI committee monthly and updated as indicated.

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Quality monitoring schedule modified based on findings.
Results to be discussed during QAPI.
5. Completion date: 1/11/2018.

On 1/11/18 at 4:00 p.m., facility staff presented current certification verifications of the identified 17 CNAs. The certifications were printed from the DHP (Department of Health Professions) website on 1/11/18. All identified CNA's had a current certification. CNA #3, who was hired on 9/19/17, had a pending violation against her certification that had not been resolved by the Board of Nursing. The following was documented on CNA #3's certification: "Additional public information: YES..."YES" means that there is information the Department of Health must make available to the public pursuant to 54.1-2400. G The Code of Virginia; please note that this may also include proceedings in which a finding of "no violation was made."

On 1/11/18 at 4:20 p.m., further interview was conducted with OSM #1. When asked the process if she were to verify a CNA's certification and found a "YES" on their certification indicating that there may be a pending violation against their certification, OSM #1 stated that she would not know what to do at that time. OSM #1 stated that she would go to the DON about the certification. OSM #1 stated that the pending violation may also need to be investigated by the administrator. OSM #1 could not recall a time when a CNA had a pending violation against their certification.

On 1/11/18 at 4:23 p.m. an interview was conducted with ASM (administrative staff member) #2, the DON. When asked the DON about her involvement in the hiring and

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certification verification process, ASM #2 stated after the application was reviewed by human resources, she would have the applicant come in for an interview and introduce the applicant to the administrator. ASM #2 stated if they liked the applicant, they would run a background check. If the background check was clean, then human resources would verify the certification. ASM #2 stated the administrator would make the final decision to hire an applicant. ASM #2 was not aware of a time where they hired an applicant with a pending violation against their certification. ASM #2 could not recall verifying CNA #3's certification. ASM #2 stated if a CNA had a pending violation, it would be the administrator decision whether the applicant was hired.

On 1/11/18 at 4:44 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that the human resources director was responsible for verifying certifications. When asked why certifications should be verified, ASM #1 stated certifications should be verified to ensure that a certification is current and in good-standing. ASM #1 stated certifications should be checked before her interview with the applicant. ASM #1 stated she cannot interview the applicant without the employee file and a copy of their current certification. ASM #1 stated all CNAs should have a current certification in their employee file. When asked the process if a CNA had a pending violation against their certification, ASM #1 stated her decision to hire an applicant would depend on the violation. ASM #1 stated that if the violation was still pending, she would not hire that person until she found additional information from the Board of Nursing. When asked if she had recently hired a CNA that had a pending violation against their certification, ASM

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#1 stated, "No, not recently. Not at this job at all." When asked what she could recall about hiring CNA #3, ASM #1 stated that she was not aware that CNA #4 had a pending violation against her certification. ASM #1 stated she would suspend CNA #3 until she receives additional information regarding her pending violation from the Board of Nursing.

On 1/11/18 at 5:25 p.m., the Administrator and DON (Director of Nursing) were able to evidence CNA #4 had been suspended until further investigation. The Administrator and DON were able to evidence they removed this CNA from the working schedule dated 1/11/18 through 1/16/18. The POC (Plan of Correction was accepted) on 1/11/18 at 5:25 p.m.

On 1/16/18 at approximately 9:30 a.m., ASM (administrative staff member) #2, the DON, stated the human resources director, OSM #2 had walked out of the facility on 1/11/18 during the middle of survey. ASM #2 presented a revised POC. The following was documented:

"Removal of Immediacy Plan of Correction- C.N.A licenses- 1/11/18

1. Identified C.N.A's certification obtained and placed in the employee file 1/11/18. Identified C.N.A's without a current license removed from the schedule.
2. A quality review of current CNA employee files completed by the Assistant Business Office Manager to ensure licenses are current and located in the file. CNA's without a current license to be removed from schedule until a license is obtained, validated, and placed in their employee file prior to accepting an assignment.

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3. ABOM (assistant business office manager)/designee re-educated by the Executive director (ED), to ensure C.N.A.'s licenses are current and located in the employee file prior to accepting an assignment. HRC re-educated by the ED (executive director) to ensure CNAs without a current license are removed from the schedule until a license is obtained, validated and placed in their employee file prior to accepting an assignment.
4. ABOM/Designee to conduct random quality monitoring of C.N.A employee files 5 times a week for 4 weeks, weekly x4 weeks then monthly and PRN. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
Results to be discussed during QAPI.
5. Completion date: 1/11/2018 "

On 1/16/18 at 9:30 a.m., CNA #3's employee file was requested along with her time card from ASM #2. When asked what CNA #3's violation was on her certification, ASM #2 stated her pending violation was from 2013 and that no violation was found. ASM #2 stated the board of nursing had not yet taken the pending violation off the website. ASM #2 stated she could not obtain additional information regarding the violation. ASM #2 stated she had also found two additional CNAs who had pending violations on their certification but they were clear to work. ASM #2 was asked to provide evidence these CNAs had no violations on their certification. ASM #2 stated she would try to get in touch with the department of health professions.

Review of CNA#3's employee file revealed she had signed a sworn statement on 9/12/17,

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indicating that she had not been convicted of or currently pending charges of murder, abduction for immoral purposes, assaults, robbery, sexual assault, arson, pandering, crimes against nature involving children, taking indecent liberties with children, abuse or neglect with children, failure to secure medical attention for an injured child, obscenity offenses, or abuse or neglect of an incapacitated adult. Further review of her employee file revealed that CNA #3's background check was not run until 1/10/2018 (Over three months after she was hired). CNA #3's background check was clean.

Review of CNA #3's time card revealed that she had worked approximately 70 shifts as a CNA providing direct patient care from 10/05/17 until 1/11/18 (when CNA #3 was suspended). Further review of the time card revealed that CNA #3 was removed from the schedule on 1/11/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #3, documented the following: "Employee was suspended via telephone secondary to violation of level 2 -#30. Employee was told that she cannot clock in or return to work until the investigation is complete. Employee verbalized understanding and stated she had a letter to bring in from the board."

Further review of the POC revealed that the facility had identified two additional CNAs, CNA #10 and CNA #11 who had pending violations on their certifications.

1. CNA #10 was hired on 6/6/17 and her certification was not verified until 9/10/17. CNA #10's background check was not completed until 1/13/18. CNA #10's background check was

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clean. Review of her time card revealed she had worked approximately 73 shifts as a CNA providing direct patient care from 9/21/17 until 1/12/18 (when CNA #10 was suspended). Further review of the time card revealed that CNA #10 was removed from the schedule on 1/12/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #10, documented the following: "Employee was suspended secondary to level 2 -#30. Employee was informed that she is suspended pending investigation. Employee stated she has a letter at home clearing her. Employee was informed to bring in. Employee comments: I went to the board of nursing for verbal abuse and they cleared it and said I wasn't guilty and cleared me from the verbal abuse and nothing was on my certification."

2. CNA #11 was hired on 2/2/15 and her certification was not verified until 9/9/17. CNA #11's background check was clean and completed in a timely manner. Review of her timecard revealed that she had worked approximately 83 shifts as a CNA providing direct patient care from 9/27/17 until 1/12/18 (when she was removed from the schedule). Further review of the time card revealed that CNA #10 was removed from the schedule on 1/12/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #11, documented the following: "Employee was suspended secondary to level 2 -#30. Employee was informed that she is suspended pending investigation. Employee stated she has a letter at home clearing her. Employee was informed to bring it in. Employee comments: I went to the state boards for having to put a woman down on the floor from a sit to stand because I went to put

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the other strap on and the chair moved. And I never had used a sit to stand before and I was told I could hook them up by myself and then go get someone to transfer."

On 1/16/18 at 11:10 a.m., an interview was conducted with OSM (other staff member) #6, the Discipline Specialist for the Virginia Board of Nursing. OSM #6 stated that CNA #3, CNA #10, and CNA #11 had no violation pending on their certification. OSM #6 stated that when a certificationd professional has a pending violation on their certification, an informal conference with the certificationd professional and board of nursing will occur. OSM #6 stated that is when the board of nursing will review the case and decided whether the certificationd professional is guilty of a violation or cleared. OSM #6 stated that all CNAs should have received a letter from the board stating that no violation was found. OSM #6 stated it takes a while for this information to come off the website. When asked the reason for each CNA to be presented to the board, OSM #6 stated, "That is not public information." OSM #6 could not give any information of when each CNA was cleared from their pending violation.

On 1/16/18 at 11:31 a.m., an interview was conducted with OSM #7, the assistant business office manager. OSM #7 confirmed education regarding certification verification and the process if a pending violation is found on the certification.

On 1/16/18 at 1:20 p.m., 1/16/18 at 1:20 p.m., the immediate jeopardy was abated and ASM (administrative staff member) #1, the administrator and ASM #2, the DON were made aware of the abatement.

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| F 729 | Continued From page 93<br>No further information was presented prior to exit. | F 729 | | |
| F 730 SS=E | Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility document review, it was determined the facility staff failed to conduct annual performance review evaluations for 79 CNAs (certified nursing assistants) currently employed in the facility.<br><br>The facility staff failed to ensure that performance review evaluations were conducted annually.<br><br>The findings include;<br><br>On 1/11/18 at approximately 9:00 a.m. a review was conducted of 79 CNA employee records. These records were all current CNAs who were verified as working in the two weeks prior to this survey. There was no evidence in all 79 CNA employee records that performance review evaluations had been conducted on an annual basis.<br><br>On 1/11/18 at 5:35 p.m., an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were asked who conducted employee performance | F 730 | F730: Nurse Aide Perform Review 12hr/yr. In-service<br><br>1. Identified Certified Nursing Assistance (CNA)'s received performance evaluations on1/24/18.<br><br>2. Quality Review completed by the Human Resources Coordinator (HRC)/designee to ensure CNAs receive their performance evaluation presented to them by the DCS/designee during the month of their annual date of hire date and placed in the employee file. Follow up based on findings.<br><br>3. Director of Nursing (DON) re-educated by the Executive Director (ED) regarding ensuring CNAs to receive their annual performance evaluation presented to them during the month of their annual date of hire.<br>HRC re-educated by the ED/DON regarding ensuring the HRC develops a file alerting the DCS of annual performance reviews due monthly.<br>HRC re-educated by the ED/DON regarding the responsibility for maintaining the appropriate documentation in the employee file. | |

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review evaluations. ASM #2 stated it was a collaborative effort between the team members and department supervisor. ASM #2 further stated, "It is a gray area between HR (human resources) and nursing staff. We have had a large turnover. It is a work in process."

On 1/16/18 at 10:25 a.m. an interview was conducted with CNA #17. CNA #17 was asked if she had received a performance review evaluation on the anniversary of her employment every year. CNA #17 stated that she had received a performance review evaluation a few months ago but that was all.

1/16/18 at 10:50 a.m. an interview was conducted with CNA #15. CNA #15 was asked if she had received a performance review evaluation on the anniversary of her employment every year. CNA #15 stated that she was supposed to get one "today."

On 1/16/18 at 1:40 p.m. an interview was conducted with ASM #1 and ASM #2. ASM #1 and ASM #2 were asked to explain the process of conducting performance review evaluations. ASM #2 stated, "Performance evaluations should be done by the unit manager, charge nurse and or myself. Our HR department is responsible to let the staff know when the performance evaluation is to be done. HR advises the supervisor the evaluation is due to be done." ASM #2 was asked who checks that the performance evaluations are done. ASM #2 stated, "It would have been HR. We have a broken system, we have had a lot of turnover in our HR department and our current HR person walked out last week."

4. HRC/designee to conduct random quality monitoring to ensure CNAs receive their performance evaluation presented to them by the DCS/designee during the month of their annual date of hire date and placed in the employee file 2 times weekly x 4 weeks then monthly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 3-2-18.

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| F 730 | Continued From page 95<br>No further information was provided prior to the end of the survey process. | F 730 | | |
| F 840 SS=D | Use of Outside Resources<br>CFR(s): 483.70(g)(1)(2)<br><br>§483.70(g) Use of outside resources.<br>§483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section.<br><br>§483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-<br>(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and<br>(ii) The timeliness of the services.<br>This REQUIREMENT is not met as evidenced by.<br>Based on staff interview and facility document review, it was determined the facility staff failed to obtain a contract with an outside provider who is currently providing services in the facility.<br><br>The facility staff failed to obtain a contract with the wound care physician group prior to providing services in the facility.<br><br>The findings include: | F 840 | **F840: Use of Outside Resources**<br><br>1. Contract with wound care physician obtained 1/10/18.<br><br>2. Quality Review completed by the Executive Director (ED)/ designee to ensure outside vendors requiring a contract is current and accessible. Follow up based on findings.<br><br>3. ED re-educated by the Regional Vice President of Operations (RVPO) regarding ensuring outside vendors requiring a contract is current and accessible.<br><br>4. ED/RVPO/designee to conduct random quality monitoring of outside vendors requiring a contract ensuring contracts are current and accessible weekly x2 weeks, monthly x 2 months, and quarterly and PRN as indicated.<br>Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.<br><br>5. Date of Compliance 3-2-18. | |

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On 1/11/18, the contract of outside providers was requested from the administrator. On 1/11/18 at 1:30 p.m. the administrator, administrative staff member (ASM) #1, stated she did not have a contract for (name of wound care specialist).

An interview was conducted with ASM #1 on 1/11/18 at 2:45 p.m. When asked about the process followed for ensuring contracts are obtained with providers of services in the building, ASM #1 stated, "If we get a new company, we get a contract. I pass it on to the corporate office and legal review team. They send it back with any changes they have requested and then confer with the provider. When the corporate team says I can sign it, I sign it and send a copy to the vendor and upload it to our portal with contracts. I keep a copy in a book here at the facility also. It's not required but I prefer to keep a physical copy here in the contract book in my office."

The administrator, director of nursing and the regional director of clinical services were made aware of the above concern on 1/11/18 at 5:32 p.m. A copy of the facility policy on contracts was requested as was the date that the wound care specialist started providing services in the facility.

On 1/16/18 at 9:38 a.m., ASM #1 presented a copy of the policy, "Contract Management." The policy documented in part, "Policy: All contacts entered into by Facilities should be routed through e contract management software to ensure they receive appropriate approval prior to execution and are properly stored. Procedure: 1. All contracts should be submitted via the contract management software...2. The contract system can be accessed on the (corporation network) ....3. Once a request is submitted through the

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| F 840 | Continued From page 97<br>contract management system, it will be routed to the appropriate operational and financial personnel for review and approval. The contract will also be reviewed by the legal department. a. All contracts should be submitted as soon as possible so proper approval can be received prior to entering a contract. 4. Contracts should not be executed until the requestor receives a clear email instruction to do so. 5. Fully executed contracts should be emailed to (email of corporate legal team) or faxed to the legal department immediately upon execution for storage in the contract system.<br><br>On 1/16/18 at 9:38 a.m. ASM #1 stated that the wound care specialist group had been providing services to the residents since November 2015.<br><br>No further information was provided prior to exit. | F 840 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections | F 880 | | |

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

1. Linen cart removed from resident 3's room on 1/10/18.
Resident # 2 did not suffer and s/s of physical or psychosocial adverse effects.
Nurse aide who cared for resident #2 re-educated regarding Infection Control practices r/t residents on Isolation precautions.

2. Quality review by the Director of Nursing (DON)/Staff Education Nurse/designee completed regarding residents on Isolation precautions to ensure Infection Control practices are followed per professional standards. Follow up based on findings.
Quality review by the Executive Director (ED)/DON to ensure linen carts are not being stored in resident rooms. Follow up based on findings.

3. Current staff re-educated by the DON/ Staff Education Nurse/designee to ensure residents on isolation precautions to ensure Infection Control practices are followed per professional standards.
Current staff re-educated by the DON/ Staff Education Nurse/designee to ensure linen carts are not being stored in resident rooms.

4. ED/DCS/designee to conduct random quality monitoring regarding residents on Isolation precautions to ensure Infection Control practices is followed per professional standards 4 times weekly x 4 weeks, 3 times weekly x 4 weeks then twice weekly and PRN as indicated.

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| F 880 | Continued From page 99<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow infection control practices for one of 3 nursing units (the dementia unit) and for one of 6 residents in the survey sample, Resident #2.<br><br>1. The linen cart for the entire dementia unit, containing clean linens for all the residents, was observed stored in Resident #3's room.<br><br>2. The facility staff failed to use appropriate contact precautions when entering Resident #2's room.<br><br>The findings include:<br><br>1. The linen cart for the entire dementia unit, containing clean linens for all the residents, was observed stored in Resident #3's room.<br><br>Resident #3 was admitted to the facility on 7/10/15 with the diagnoses of but not limited to chronic kidney disease, high blood pressure, Alzheimer's Disease, diabetes, and psychosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment | F 880 | ED/DCS/designee to conduct random quality monitoring through mock survey rounds to ensure linen carts are not being stored in resident rooms 4 times weekly x 4 weeks, 3 times weekly x 4 weeks then twice weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.<br><br>5. Date of Compliance 3-2-18. | |

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Reference Date) of 10/17/17. Resident #3 was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 1 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded requiring total care for bathing; extensive care for bed mobility, dressing, toileting, and hygiene; Supervision to limited assistance for ambulation; and as frequently incontinent of bowel and bladder.

On 1/10/18 at 5:11 p.m., 6:10 p.m., and 7:35 p.m., an observation was made of Resident #3's room. A mesh-covered linen cart for the unit containing clean sheets, blankets, towels, wash cloths, bed protector pads, and assorted sized resident briefs, was observed being stored in Resident #3's room. This was a linen cart for the entire unit and not for the one resident.

On 1/10/18 at 7:35 p.m., in an interview with CNA #1 (Certified Nursing Assistant) she stated that the linen cart was being stored in resident rooms (not just Resident #3, but at any given time may be in any other resident's room) because the fire marshal said the cart could not be stored in the storage room; and, that there was a resident on the unit that would take items from the cart, so they could not leave it in the hallway. CNA #1 did not recognize that this was an infection control issue.

A review of the facility policy, "Exposure Control Plan: Linen Handling" documented, "....Clean linen to be stored in a closed closet or a covered linen cart....Clean linen from the Laundry Department to the care areas should be transported to linen storage areas using a covered cart..." The policy did not indicate that

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linen carts should not be stored in a resident's room.

On 1/11/18 at 5:33 p.m., the Administrator was made aware of the findings. The Administrator stated the Fire Marshal never said the linen cart could not be stored in the storage room. No further information was provided by the end of the survey.

2. The facility staff failed to use appropriate contact precautions when entering Resident #2's room.

Resident #2 was admitted to the facility on 9/24/16 with diagnoses that included, but were not limited to, dementia, acute kidney failure, dehydration and aphasia (difficulty finding words).

Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/8/17, coded Resident #2 as being able to answer the questions provided on her BIMS (brief interview for mental status). The staff assessment for Resident #2's cognitive ability for daily decision making coded Resident #2 as a three (3), indicating that Resident #2 was cognitively severely impaired.

On 1/10/18 at 6:45 p.m. Resident #2's room was observed with a cart outside the door containing personal protective equipment (PPE) and a sign that stated Resident #2 was on contact precautions. Resident #2 was observed being assisted with ambulation to her room by a CNA. On entering the room CNA (certified nursing

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assistant) #18 did not don any of the PPE. CNA #18 assisted Resident #2 to sit on her bed and began helping her with her meal. CNA #18 was observed touching Resident #2's meal tray with bare hands and cutting Resident #2's food. CNA #18 was then removed an envelope from Resident #2's bedside table and begin fanning herself, stating that she was hot. At 6:55 p.m. CNA #18 left Resident #2's room, she did not wash her hands or use any anti-bacterial solution. CNA #18 then proceeded to retrieve a cart and entered other resident rooms to remove dinner trays.

On 1/10/17 at 7:35 p.m. an interview was conducted with CNA #18. CNA #18 was asked to explain the isolation procedures currently in place for Resident #2. CNA #18 stated Resident #2 was on contact precautions and she should put a gown on and gloves when entering the room. CNA #18 further stated she was aware that she had not done that when entering Resident #2's room, but she was more focused on getting Resident #2 back to her room. CNA #18 stated, "I should have gowned and gloved." CNA #18 was asked what Resident #2 was on isolation for. CNA #18 stated, "She has head lice, and it can be spread." CNA #18 was asked what should she do to protect other residents from being infected, CNA #18 stated, "I should have washed my hands, I did not do it that time, I should have done it, just didn't do it."

On 1/11/18 at 2:16 p.m. an interview was conducted with RN (registered nurse) #4. RN #4 was asked what should happen for a resident is on isolation. RN #4 stated, "Always do the PPE, gown and gloves, before entering the room." RN #4 was asked what should be done differently if

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the resident was known to have head lice. RN #4 stated, "The staff should place a shower cap on their head before entering."

On 1/11/18 at 5:35 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings at this time and a policy regarding infection control was requested.

A review of the facility policy titled, "Isolation - Categories of Transmission - Based Precautions" revealed, in part, the following documentation; "Contact Precautions 1. In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident. 4. Gloves and Handwashing. a. In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room. c. Remove gloves before leaving the room and perform hand hygiene. 5. Gown. a. Wear a disposable gown upon entering the Contact Precautions room or cubicle."

No further information was provided prior to the end of the survey process.

F 947 SS=E — Required In-Service Training for Nurse Aides — CFR(s): 483.95(g)(1)-(4) — F 947

§483.95(g) Required in-service training for nurse aides.
In-service training must-

§483.95(g)(1) Be sufficient to ensure the

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continuing competence of nurse aides, but must be no less than 12 hours per year.

§483.95(g)(2) Include dementia management training and resident abuse prevention training.

§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined that the facility staff failed to ensure 18 of 79 CNAs (certified nursing assistants) had completed their mandatory 12 hours of training by their anniversary dates of employment.

The findings include;

On 1/11/18 at approximately 9:00 a.m. a review was conducted of 79 CNA employee records. These records were all current CNAs who were verified as working in the two weeks prior to this survey. There was no evidence in all 79 CNA employee records that 12 hours of mandatory education had been completed by their anniversary dates of employment.

On 1/11/18 at 5:35 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the

**F947: Required In-Service Training for Nurse Aides**

1. Current residents received care and services per professional standards and did not suffer and s/s of physical or psychosocial adverse effects

2. Quality review of current CNA files completed by the Staff Education Nurse/Director of Nursing (DON)/designee to ensure C.N.A's receive education per the Annual Education Calendar to validate completion of 12HR required trainings from hire date to hire date. Follow up based on findings.

3. Staff Education Nurse re-educated by the DON regarding ensuring CNA's receive education per the Annual Education Calendar to validate completion of 12HR required trainings from hire date to hire date.

4. Staff Education Nurse/DON/Designee to conduct random quality monitoring of CNA files to ensure CNA's receive education per the Annual Education Calendar to validate completion of 12HR required trainings from hire date to hire date 3 times weekly x 4 weeks, 2 times weekly x 4 weeks then weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 3-2-18.

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director of nursing. ASM #1 and ASM #2 were asked to provide evidence that all CNAs had received their 12-hour mandatory training by their anniversary dates.

On 1/16/18 at approximately 11:00 a.m. ASM #2, the director of nursing, provided a print out of all CNAs and a transcript of their education, including the total hours. A review was conducted by this writer of the information provided.

On 1/16/18 at approximately 1.00 p.m. ASM #2 was asked to provide further evidence for 18 of the 79 CNAs that documented completion of the 12 hours mandatory training.

On 1/16/18 at approximately 1:30 p.m. ASM #2 returned to this writer and stated that she was unable to provide evidence that 18 of the 79 CNAs in question had received 12 hours of the mandatory education.

On 1/16/18 at 1:40 p.m. a meeting was conducted with ASM #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the concern that not all CNAs had the required mandatory education documented as completed. ASM #1 and ASM #2 were asked to state the requirement regarding CNA training. ASM #2 stated, "They are supposed to have 12 hours of mandatory education on their anniversary date each year." ASM #2 confirmed there were 18 CNAs without the required education. ASM #1 and ASM #2 were asked who was responsible for ensuring the staff was completed the training. ASM #2 stated the staff coordinator was responsible but she was unavailable for interview. ASM #2 further stated, "Education begins at orientation according to the

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board of nursing and (name of corporation) guidelines. We do a lot of abuse training. We have monthly scheduled classes." ASM #2 was asked how the facility tracks who has completed the education. ASM #2 stated, "We have a calendar of mandated training, we schedule classes in the computer system and we also make written material available." ASM #2 was asked who ensures that the education is completed. ASM #2 stated, "We have had some missed opportunities."

No further information was provided prior to the end of the survey process.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 434.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 552 and 180.