STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. BUILDING _____ B. WING _____	C 02/15/2018

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AVANTE AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/13/18 through 02/15/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Four complaint(s) were investigated during the survey.	E 000	**F 000** Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and /or executed solely because required by the provisions of Health Code Section 1280 and 42 C.F.R. 405.1907.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/13/18 through 2/15/18. Corrections are required for compliance with the following Federal Long Term Care requirements. Complaints were investigated during the course of the survey. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 94 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3 closed record reviews.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655	**F 655** 3/16/18 1. Baseline care plan for Resident 92 was developed within 48 hours, but not reviewed with legal representative within 48 hours. 100% audit of new admissions within last 30 days was conducted. 2. Protocol will be amended so that baseline care plan will be reviewed with resident and/legal representative within 48 hours of admission. 3. Weekly audit will occur for 30 days on all new admissions by MDS Coordinator. 4. Inservice completed with Interdisciplinary Team and Nurse Administration on March 8, 2018 regarding new protocol. 5. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy M. Bender — TITLE: Administrator — (X6) DATE: 3/11/2018

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

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F 655	Continued From page 1 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff failed to develop a baseline care plan within 48 hours of admission for 1 of 19 Residents in the survey sample, Resident # 92. The findings included: The facility staff failed to develop a baseline care	F 655		

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F 655	Continued From page 2 plan within 48 hours of admission for Resident # 92. Resident # 92 is an 89-year-old female that was originally admitted to the facility on 12/12/17, with a readmission date of 1/27/18. Diagnoses included but not limited to: major depressive disorder, dementia, atrial fibrillation, and hypothyroidism. The most recent MDS (minimum data set) was a 14 day assessment with an ARD (assessment reference date) of 2/10/18. Section C of the MDS assesses cognitive patterns. In Section C0500, Resident # 92 had a BIMS (brief interview for mental status) score of 7/15, which indicated severe cognitive impairment. On 2/15/18 at 10:22 am, the clinical record for Resident # 92 was reviewed. The baseline care plan conference form had documented that the care plan was developed and reviewed with the resident representative on 12/18/17. The surveyor spoke with the administrator and discussed Resident # 92 being admitted on 12-12-17 and the baseline care plan being implemented and reviewed with the resident representative 6 days later. Administrator agreed and stated that she was aware that the baseline care plan should have been implemented and reviewed with the resident and the family within 48 hours of admission. According to the facility policy for "Baseline Care Plan", "The baseline care plan must: Be developed within 48 hours of a resident's admission." On 2/15/18 at 5:35 pm, the administrative team	F 655		

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F 655	Continued From page 3 was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 2/15/18.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and clinical record review, the facility staff failed to ensure 3 of 19 dependent residents (Resident #88, Resident #293, and Resident #20) were provided ADL (activities of daily living) care. The findings included: 1. The facility staff failed to provide showers or bed baths for Resident #88. The surveyor reviewed the clinical record of Resident #88 2/13/18 through 2/15/18. Resident #88 was admitted to the facility 11/3/17 with diagnoses that included but not limited to vascular dementia without behavioral disturbances, heart failure, pacemaker, major depressive disorder, slow transit constipation, hyperlipidemia, anxiety, cataracts, Alzheimer's disease, hypertension, myocardial infarction, dysphagia, Gastro-esophageal reflux disease (GERD), and seizures. Resident #88's quarterly minimum data set (MDS) with an assessment reference date (ARD)	F 677	**F 677** 1. Residents 88, 293, and 20 are currently receiving showers and receiving oral care. A 100% audit of showers/baths & oral care was conducted for past 30 days. 2. Weekly audits of baths/showers & oral care will be conducted for 30 days and then randomly by the DON and/or designee. 3. Inservices regarding ADL care have been initiated with all nursing staff. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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F 677	Continued From page 4 of 11/3/17 assessed the resident with a BIMS of 8/15 in Section C Cognitive Patterns. Section G Functional Status assessed Resident #88 to require limited assistance of one person for personal hygiene and extensive assistance of one person for bathing. Resident #88 was not assessed with any functional limitations in range of motion. Resident #88's person centered care plan initiated 1120/2017 identified a focus area for ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, limited mobility. Interventions: Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated. The surveyor observed Resident #88 during the initial tour on 2/13/18 at 1:56 p.m. The resident was observed sitting in his room in his wheelchair. The resident had a small growth of chin hair and was wearing a rust colored plaid shirt. The resident was observed again in the dining room on 2/13/18 at 5:47 p.m. Resident #88 was wearing the same rust colored plaid shirt and stubble of hair noted on chin. The surveyor observed Resident #88 on 2/14/18 multiple times during the day-during breakfast at 8:30 a.m., lunch at 12:15 p.m., and again at 3:20 p.m. Resident #88 was wearing the same clothes and continued to have the stubble of facial hair. The surveyor reviewed Resident #88's bath/shower records on 2/14/18. Bath records indicated only four (4) showers since admission on 11/3/17. The surveyor requested ADL sheets	F 677		

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F 677	Continued From page 5 for Jan/Feb 2018 from the director of nursing (DON). The surveyor observed Resident #88 on 2/14/18 at 3:51 p.m. Resident #88 still had stubble on the face but the clothes had been changed. The jogging pants Resident #88 was wearing had bleach stains in the front. The surveyor reviewed the January 2018 and February 2018 ADL records on 2/15/18 at 11:26 a.m. The shower records documented showers on 1/3/18, 1/6/18, 1/10/18, and 2/4/18. The surveyor informed the administrator of the concern with Resident #88's baths/showers on 2/15/18 at 10:32 a.m. The administrator stated she had done a "QAPI (Quality Assurance Performance Improvement)" and had harped and harped about documentation. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern on 2/15/18 at 4:44 p.m. No further information was provided prior to the exit conference on 2/15/18. 2. The facility staff failed to provide Resident #293 with showers or bed baths. The clinical record of Resident #293 was reviewed 2/13/18 through 2/15/18. Resident #293 was admitted to the facility 2/2/18 with diagnoses that included but not limited to Type 2 diabetes mellitus, fracture of left femur, iron deficiency anemia, paroxysmal atrial fibrillation, dementia, pain, protein calorie malnutrition,	F 677		

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F 677	Continued From page 6 insomnia, functional dyspepsia, neuromuscular dysfunction of brain, ataxic cerebral palsy, unspecified intellectual disabilities, paraplegia, major depressive disorder, hypertension, and sacral pressure ulcer. Resident #293's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/9/18 assessed the resident with a BIMS of 7/15 in Section C Cognitive Patterns. Section G Functional Status assessed Resident #293 to require extensive assistance of 2 + persons for bed mobility and personal hygiene. Bathing was coded 8/8 (activity did not occur). Resident #293 had functional limitations in both lower extremities. Resident #293's person centered care plan initiated 2/4/18 identified the focus area of ADL (activities of daily living) self-care deficit r/t (related to) dementia, paraplegia, and left femur fracture. Interventions: Bathing/Showering: provide sponge bath when a full bath or shower cannot be tolerated. The surveyor observed and interviewed Resident #293 during breakfast on 2/14/18 at 8:27 a.m. Resident #293 stated he had never had a bath or shower since admitted to the facility. The surveyor reviewed the shower/baths record for February 2018. The activities of daily living (ADL) record documented one bath on 2/6/18. The surveyor requested the February 2018 showers/baths from the director of nursing (DON) on 2/15/18. The surveyor received and reviewed Resident #293's baths/showers since admission on 2/2/18	F 677		

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F 677	Continued From page 7 on 2/15/18 at 10:54 a.m. from the regional minimum data set registered nurse. Regional MDS RN confirmed that Resident #293 had one bath and one shower since admission on 2/2/18. The surveyor informed the administrator of the concern with Resident #293's baths/showers on 2/15/18 at 10:32 a.m. The administrator stated she had done a "QAPI" and has harped and harped about documentation. The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concern on 2/15/18 at 4:44 p.m. No further information was provided prior to the exit conference on 2/15/18. 3. The facility staff failed to ensure/provide Resident #20 showers or bed baths and failed to provide oral care. The clinical record of Resident #20 was reviewed 2/13/18 through 2/15/18. Resident #20 was admitted to the facility 6/13/06 and readmitted 11/8/17 with diagnoses that included but not limited to multiple sclerosis, Type 2 diabetes mellitus, acute kidney failure, urinary tract infections with extended spectrum beta lactamase, Parkinson's disease, and hypertension. Resident #20's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/30/17 assessed the resident with a BIMS of 15/15 in Section C Cognitive Patterns. Section G Functional Status assessed Resident #20 to require extensive	F 677		

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F 677	Continued From page 8 assistance of 2 + persons for personal hygiene. Resident #20 was totally dependent on one person for bathing. Resident #20 had functional limitations in range of motion of both lower extremities. Resident #20's person centered care plan initiated 6/24/2012 and revised on 12/4/2017 focused on ADL (activities of daily living) self-care performance deficit r/t (related to) impaired balance and impaired functional mobility with dx (diagnosis) of MS (multiple sclerosis) and Parkinson's. Interventions: BATHING: Assist with 2 showers per week per facility schedule as per Resident #20's preference. Assist with oral care bid (twice a day) and prn (as necessary). Resident #20 has her own teeth. (a) The surveyor observed Resident #20 during the evening meal on 2/13/18 and again during the breakfast meal on 2/14/18. The surveyor interviewed the resident on 2/14/18 at 3:41 p.m. Resident #20 stated she had been getting a bed bath recently but no showers. During the interview, a friend of Resident #20's arrived and with Resident #20's permission, sat in on the interview. The surveyor reviewed the 1/17/18 through 2/15/18 shower records. Resident #20 had one shower on 1/30/18 per documentation on the ADL (activities of daily living) record. (b) During the interview with Resident #20, the resident was asked if the staff are brushing her teeth. The surveyor was close enough during the interview to smell Resident #20's breath and observed her teeth were discolored (greyish in color) with particles of food debris observed.	F 677		

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F 677	Continued From page 9 Resident #20 stated the staff were not brushing her teeth. The friend stated an electric toothbrush would be nice. The friend stated either she or the brother-in-law could bring her an electric toothbrush if it was ok with the facility. The surveyor observed Resident #20 sitting in a Geri chair prior to lunch on 2/15/18 at 11:30 a.m. The surveyor noted her hair appeared to be "greasy" and the resident stated staff had not brushed her teeth. The surveyor requested licensed practical nurse #1 to see if a toothbrush or toothpaste could be located as Resident #20 wanted her teeth brushed. L.P.N. #1 looked for a toothbrush and tooth paste but was unable to find any in the resident's room. L.P.N. #1 got a new toothbrush and a new tube of toothpaste. With assistance from L.P.N. #1, Resident #20 was able to brush her teeth. The surveyor informed the administrator of the above concern on 2/15/18 at 2:47 p.m. The administrator was asked about any dental services in the facility. The administrator stated a contract for a mobile dentist had been obtained and had been sent to the corporate office. The surveyor informed the administrator, the director of nursing and the regional registered nurse of the above concerns with bathing and oral care in the end of the day meeting on 2/15/18 at 4:44 p.m. No further information was provided prior to the exit conference on 2/15/18.	F 677		
F 684	Quality of Care	F 684		

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F 684 SS=D	Continued From page 10 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain weekly weights for 1 of 19 residents (Resident #69). The findings included: The facility staff failed to obtain weekly weights as ordered by the physician for Resident #69. The clinical record of Resident #69 was reviewed 2/13/18 through 2/15/18. Resident #69 was admitted to the facility 11/9/12 with diagnoses that included but not limited to demyelinating disease of central nervous system, mental disorders, contractures, dysphagia, oropharyngeal phase, epilepsy, anxiety, major depressive disorder, constipation, Vitamin D deficiency, hypertension, mood disorder, and pseudobulbar affect. Resident #69's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/20/18 assessed the resident with a BIMS of 00/15 in Section C Cognitive Patterns. Section G Functional Status coded the resident for eating as 4/2 (total dependence on 1 person). Section K coded the	F 684	**F 684** **1. Weekly weights for Resident 69 are being been obtained and documented.** **2. A 100% audit for all residents receiving weekly weights for last 30 days was conducted.** **3. A weekly audit will be conducted for 30 days on residents with weekly weights by the DON and/or designee.** **4. Inservices initiated with licensed nursing staff regarding documentation of weekly weights in Electronic Medication Administration Record.** **5. The results of the ongoing audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.**	3/16/18

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F 684	Continued From page 11 resident as a weight loss-not on a prescribed weight loss regimen. Weight was 121 pounds. FT (feeding tube) marked. Resident #69's person centered care plan identified a focus area initiated 9/13/2016 that read in part "Resident #69 is at risk for dehydration or potential fluid deficit r/t (related to) self-care deficit, dependent on staff for her main nutritional intake via tube feeding with cognitive deficit. Interventions: Residents weight per protocol/MD (medical doctor) order." The February 2018 electronic physician's orders were reviewed. Resident #69 had an order for weekly weight on Mondays one time a day every Monday for TF (tube feeding) changes-Order date 10/12/17 Start Date 10/16/17. Resident #69's weights reviewed in the electronic record were as follows: 10/20/17 119 (mechanical lift) 10/23/17=122 (Hoyer lift) 11/6/17=120 (done with mech lift) 12/7/17=122 1/4/18=121 The surveyor was unable to locate the weekly weights as ordered by the physician in October 2017 and requested the assistance of the director of nursing on 2/15/18 at 3:32 p.m. The DON stated restorative nursing does the monthly weights and the nursing staff do the weekly weights. The DON stated the nursing staff are to document the weekly weights on the MAR (medication administration record)/TAR (treatment administration record). The surveyor requested the November 2017, December 2017 and January 2018 MARs/TARs.	F 684		

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F 684	Continued From page 12 The surveyor reviewed the December 2017, January 2018 and February 2018 eMARs. Each eMAR had an entry that read "Weekly weights on Mondays one time a day for TF changes -Start date-10/16/17." The DON stated the nurses were marking that the weights were being obtained as indicated by their initials in the boxes but no weights were documented. The DON stated "The weights are documented as being done but the results are not put anywhere. I need to know the weights." The surveyor informed the administrator, the director of nursing and the regional registered nurse of the above concern in the end of the day meeting on 2/15/18 at 4:44 p.m. No further information was provided prior to the exit conference on 2/15/18.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686	**F 686** 1. Skin assessment for Resident 69 was corrected on 2/14/18. A 100% audit was conducted for past 30 days on all recent skin assessments. 2. Weekly audits for 30 days will be conducted to review skin assessments for accuracy in completion by the DON and/or designee. 3. Inservices initiated for all licensed nurses regarding accurate completion of skin assessments. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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F 686	Continued From page 13 by: Based on observation, staff interview, facility document and clinical record review, the facility staff failed to ensure weekly skin assessments were accurate for 1 of 19 residents (Resident #69). The findings included: The facility staff failed to ensure the weekly skin assessment completed 2/8/18 for Resident #69 was accurate. The clinical record of Resident #69 was reviewed 2/13/18 through 2/15/18. Resident #69 was admitted to the facility 11/9/12 with diagnoses that included but not limited to demyelinating disease of central nervous system, mental disorders, contractures, dysphagia, oropharyngeal phase, epilepsy, anxiety, major depressive disorder, constipation, Vitamin D deficiency, hypertension, mood disorder, and pseudobulbar affect. Resident #69's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/20/18 assessed the resident with a BIMS of 00/15 in Section C Cognitive Patterns. Section M Skin Conditions did not assess Resident #69 for any unhealed pressure areas. Resident #69's person centered care plan identified a focus area initiated 11/9/2012 and revised 2/15/2017 for the potential for pressure ulcers related to incontinence, immobility, and contractures associated with neurological dx (diagnosis). Resolved stage III pressure ulcer of coccyx. Has chronic head movements with patches of missing hair from rubbing.	F 686		

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F 686	Continued From page 14 Interventions: Follow facility protocols for the prevention of skin breakdown. Obtain weekly skin checks and document. Notify Dr. (doctor) of any changes seen in skin integrity. A progress note dated 2/5/18 12:44 p.m. read "Assessment: note left to f/u (follow-up) on rsd (resident) left 5th toe. Observed rsd lat. (lateral) 5th toe. 100% black eschar meas (measuring) 1 x 1 x NM (not measured) cm (centimeter). No exudate between 4th and 5th toe open area meas. 0.3 x 1 x 0.1 cm. No exudate. Slight moisture observed. Area had been cleaned by unit nurse prior to being observed." The second progress note was dated 2/8/18 at 15:29 (3:29 p.m.) and read "Assessment: Dr.___ (name omitted) in to assess and tx (treat) on 2/8/18. See md (doctor) progress note. rsd sitting up in chair in room. No facial grimaces or body language indicating discomfort during visit. Left fifth toe unstageable meas. 3 x 1.5 NM cm cluster wound. Light serous exudate. 30% thick adherent necrotic tissue (eschar). 20% thick adherent necrotic tissue and 50% skin. Mother updated 2/6/18. Requested alt (alternating) air mattress and asked staff to limit time positioned on left side d/t (due to) rsd pulls left foot up under buttock when lying on left side. Rsd up in chair daily as tolerated. Rsd tube feeding and HOB (head of bed elevated) to prevent aspiration. Rsd incont. (incontinent) and staff provides freq (frequent) incontinence care. prevalon boots bil (bilaterally)." The weekly skin assessment completed 2/8/18 at 16:50 (4:50 p.m.) read "A skin observation was completed on Resident #69. Areas noted upon observation were. No new issues noted."	F 686		

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F 686	Continued From page 15 Physician order dated 2/8/18 at 13:47 (1:47 p.m.) read "Left 4th and 5th toe clean w/(with) n. (normal) saline and apply betadine and gauze between toes daily until resolved" and order dated 2/8/18 at 13:49 (1:49 p.m.) read "Left fifth toe paint w/betadine daily til resolved." The surveyor observed wound care on 2/14/18 at 9:30 a.m. with the wound care licensed practical nurse #1 (WCN). The WCN stated the staff notified her of the area to the left little toe and between 4th and 5th toes on 2/5/18. WCN stated the physician was notified, the resident was started on an antibiotic and treatment orders given. The surveyor observed wound care to a nickel size area on Resident #69's left little toe. The surveyor interviewed the director of nursing (DON) on 2/14/18 at 9:30 a.m. The DON stated the nurse incorrectly assessed the resident. The surveyor requested the 2/8/18 skin assessment and requested the facility policy on wound care assessments/pressure ulcers. The surveyor reviewed the facility policy titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" on 2/15/18. The policy read in part "Assessment and Recognition 2. In addition, the nurse shall observe and document/report the following: b. Full observation of pressure sore including location, stage or description, length, width and depth, presence of exudates or necrotic tissue." The surveyor informed the administrator, the director of nursing and the regional registered nurse of the above concern in the end of the day meeting on 2/15/18 at 4:44 p.m.	F 686		

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F 686	Continued From page 16 No further information was provided prior to the exit conference on 2/15/18.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690	**F 690** 1. Catheter output for Resident 293 is being documented, as well as covered for privacy, anchored, and positioned correctly to prevent contamination. A 100% audit of all residents with catheters was conducted for past 30 days. 2. A weekly audit for residents with catheters will be conducted for 30 days by the DON and/or designee. 3. Inservices initiated for nursing staff regarding documenting output, infection control of catheters, privacy, and need to anchor. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/12/18

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F 690	Continued From page 17 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide appropriate treatment and services for care of a resident with a clinically-justified indwelling catheter for 1 of 19 residents (Resident #293). The findings included: The facility staff failed to ensure Resident #293's indwelling Foley catheter was anchored, failed to ensure the indwelling Foley catheter drainage bag was covered for privacy, failed to ensure the urine drainage sprout did not come into contact with the floor and failed to record the urine output from the Foley catheter. The clinical record of Resident #293 was reviewed 2/13/18 through 2/15/18. Resident #293 was admitted to the facility 2/2/18 with diagnoses that included but not limited to neurogenic bladder, Type 2 diabetes mellitus, fracture of left femur, iron deficiency anemia, paroxysmal atrial fibrillation, dementia, pain, protein calorie malnutrition, insomnia, functional dyspepsia, neuromuscular dysfunction of brain, ataxic cerebral palsy, unspecified intellectual disabilities, paraplegia, major depressive disorder, hypertension, and sacral pressure ulcer. Resident #293's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/9/18 assessed the resident with a BIMS of 7/15 in Section C Cognitive Patterns. Section H Bladder and Bowel	F 690		

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F 690	Continued From page 18 was coded for an indwelling catheter, external catheter and an ostomy. Resident #293's person centered care plan initiated 2/4/18 identified a focus area of Foley catheter d/t (due to) neurogenic bladder. Interventions: CATHETER: The resident has 18 French 10 cc (cubic centimeter) catheter. Position catheter bag tubing below the level of the bladder and away from entrance room door. Empty catheter bag q (every) shift. The surveyor observed Resident #293 on 2/14/18 at 8:18 a.m. Upon entrance to the room, the resident's Foley drainage bag was observed at the entrance to the door. The drainage bag contained clear yellow urine. The surveyor interviewed Resident #293 upon completion of his breakfast. The surveyor sat in a folding chair near the foot of the resident's bed. The surveyor observed the drainage spout from the indwelling Foley catheter touching the floor. The administrator entered Resident #293's room, visualized the uncovered urinary drainage bag/spout on the floor, and then left the room. The surveyor observed Resident #293 in bed on 2/15/18 11:47 a.m. The surveyor observed from the door the Foley catheter and observed yellow urine in the uncovered bag. The surveyor spoke with licensed practical nurse #2, who stated he would conceal the drainage bag. The surveyor observed wound care on 2/15/18 at 9:31 a.m. with the wound care licensed practical nurse #1 and with the assistance of certified nursing assistant #1. Resident #293 was positioned in bed for wound care. The surveyor observed the indwelling Foley catheter was not	F 690		

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F 690	Continued From page 19 anchored. The surveyor asked C.N.A. #1 if Foley catheters were to be anchored. C.N.A. #1 stated "it should be anchored." The February 2018 physician orders read "Record Foley output QS (every shift) alert MD (medical doctor) of any s/s (sign/symptoms) of infection or diminished output." The surveyor reviewed the February 2018 electronic treatment administration record (eTAR) on 2/15/18. There was no documented output on 2/9/18 day shift. The surveyor informed the director of nursing of the above concern of no urinary output documented on 2/9/18 on day shift on 2/15/18 9:17 a.m. The DON stated she reviewed the note and didn't see anything documented on 2/9/18. The surveyor requested the 2/9/18 progress note and the facility policy on urinary catheters. The surveyor reviewed the facility policy titled "Catheter Care, Urinary" on 2/15/18. The policy read in part "General Guidelines Input/Output 2. Maintain an accurate record of the resident's daily output, per facility policy and procedure. Infection Control 2. B. Be sure the catheter tubing and drainage bag are kept off the floor. Changing Catheters 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter should be strapped to the resident's inner thighs)." The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concerns with Resident	F 690		

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F 690	Continued From page 20 #293's indwelling Foley catheter (privacy of the drainage bag, infection control, output not done, and the indwelling Foley catheter tubing unanchored) in the end of the day meeting on 2/15/18 at 4:44 p.m. No further information was provided prior to the exit conference on 2/15/18.	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to administer parenteral fluids consistent with professional standards of practice and in accordance with physician's orders for 1 of 19 residents in the survey sample, Resident # 14. The findings included: The facility staff failed to follow physician's orders for PICC (peripherally inserted central catheter) line for Resident # 14. Resident # 14 is a 70-year-old female who was admitted to the facility on 7/11/17. Diagnoses included but not limited to: type 2 diabetes mellitus, lymphedema, major depressive disorder, and cellulitis of abdominal wall.	F 694	**F 694** 1. PICC line for resident 14 was pulled on 2/16/17. 100% audit was conducted on all PICCS within last 30 days. 2. A weekly audit will be conducted for 30 days on all PICC lines and flushes by the DON and/or designee. 3. Inservices initiated for nursing staff regarding following physician orders for PICC lines and proper protocol to flush. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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F 694	Continued From page 21 The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/25/17. Section C of the MDS assesses cognitive patterns. In Section C0500, Resident # 14 had a BIMS (brief interview for mental status) score of 15/15, which indicated that she was cognitively intact. According the current physician's orders that were signed and dated by the physician on 2/15/18, Resident # 14 had orders which included but were not limited to: Heparin Lock flush Solution 100 unit/ml (milliliter) Use 3 ml intravenously every shift for PICC line patency flush Qshift (every shift) using SASH (saline, antibiotic, saline, heparin) method. Sodium Chloride Flush Solution 0.9% Use 3ml intravenously every shift for PICC patency. Monitor PICC line site for placement and s/sx (signs and symptoms) of infection every shift for PICC care. On 2/13/18 at 2:00 pm, during initial tour of the facility, the surveyor observed an IV pump in Resident #14's room with an empty bag of antibiotics hanging. On 2/14/18 at 8:25am, the surveyor was in Resident # 14's room speaking with her. According to Resident # 14, she was getting IV antibiotics for something she had on her leg. Resident # 14 stated that she is not currently receiving antibiotics. The surveyor asked Resident #14 to show her PICC line site. The surveyor observed a single lumen PICC line in	F 694		

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F 694	Continued From page 22 Resident #14's right upper arm. The PICC line was unclamped and did not have a cap on the end of the catheter. The PICC line dressing was worn and coming off and there was no date time or initials observed on the dressing to reflect the date changed. The surveyor asked Resident #14 when the last time he PICC line dressing had been changed and if the nurses had come in to flush he line. Resident # 14 stated not lately, not since I had that thing and pointed at the IV pump. The Surveyor looked at the empty bag that was hanging on the pole, the bag had Vancomycin 1 gram in 250 ml NS (normal saline) 0.9% and the date on the bag was 1/30/18. On 2/14/18 at 10:52 am, the surveyor observed Resident # 14's PICC line again. PICC line dressing was still coming off and the PICC line was unclamped with no cap on the end of the catheter. The surveyor asked Resident #14 if anyone had come in to flush he line. Resident #14 stated "No." On 2/14/18 at 3:42 pm, the surveyor observed Resident # 14's PICC line again. PICC line dressing was still coming off and the PICC line was unclamped with no cap on the end of the catheter. The surveyor asked Resident #14 if anyone had come in to flush he line. Resident #14 stated "No." On 2/15/18 at 9:05 am, the surveyor went in to speak with Resident # 14. The surveyor observed the PICC line in Resident #14's right arm, the surveyor observed Resident # 14's PICC line again. The PICC line dressing was still coming off and there was blood observed around the catheter insertion site. The PICC line was unclamped with no cap on the end of the	F 694		

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F 694	Continued From page 23 catheter. The surveyor asked Resident #14 if anyone had come in to flush he line. Resident #14 stated "No." Resident # 14 then stated, "I got this thing hung on my dress." If they are not going to use it, i want them to take this thing out. On 2/15/18 at 2:00 pm, the surveyor spoke with the director of nursing about the issues with Resident # 14's PICC line. The director of nursing stated that Resident # 14 has had a lot of infections and has required IV antibiotics and that was the reason for her having the PICC line. The surveyor expressed her concerns about Resident # 14 stating that her line had not been flushed or her dressing not being changed and that the PICC line was unclamped and did not have a cap on it. The surveyor requested that the director of nursing come into the room and look at the PICC line and the director of nursing complied. While in the room, the director of nursing assessed the PICC line and observed the dressing that was coming off with the bloody area and the unclamped catheter. The director of nursing stated to the surveyor that the needleless connector that was on the end of the PICC line was the cap. Resident # 14 reported to the director of nursing that she wanted the PICC line out of her arm since they were not using it. The director of nursing asked Resident #14 if she would agree to have another PICC line put in if they needed to give more antibiotic and Resident # 14 stated, "Yes." On 2/15/18 at 2:43 pm, three surveyors went in to speak with Resident # 14. While in the room Resident, # 14 showed the surveyors her PICC line site in her right arm. The surveyors observed the PICC line dressing that was coming off and blood at the insertion site. The surveyors also	F 694		

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F 694	Continued From page 24 observed the unclamped PICC line with the uncapped needleless connector at the end. The surveyors asked Resident # 14 is anyone had come in to flush her PICC line. Resident # 14 stated "No, not for a while, not since I had that thing." (While pointing to IV) The surveyors observed an empty IV bag that had Vancomycin 1 gram in 250 ml NS 0.9% that was dated 1/30/18. On 2/15/18 at 2:55pm, three surveyors spoke with LPN #1. The surveyors asked LPN # 1 if she had flushed Resident #14's PICC line today. LPN #1 stated that she had flushed the PICC line but she had only used the heparin and had not flushed with the saline yet. The surveyors asked how the medication was supposed to be administered and LPN # 1 stated, "It's supposed to be given using the SASH method. The surveyors then asked LPN # 1 if she gave the medication the way the doctor had ordered it, and LPN #1 stated "no." The surveyors asked to see where the heparin and sodium in the medication cart that was ordered for Resident # 14. LPN # 1 stated that there was not any more in the cart and that she got it from the stat box. The surveyors requested to see where she got the heparin. LPN #1 took the surveyors to a locked room where the stat box was located. LPN # 1 then stated, "It's a new box because it's all green tags." The surveyors asked to see the slip where LPN #1 had signed out the heparin. LPN # 1 stated, "I did not sign it out." LPN# 1 then looks into a cabinet in the room and removes a heparin flush and stated, "I got it from here." (Referring to the cabinet) The surveyors asked LPN # 1 where she got the medication and she stated she got it from the cabinet. The survey team stated to LPN#1 first you said you got it from the stat box, then you are saying you got it from the cabinet. You did not	F 694		

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	495156	A. BUILDING _____ B. WING _____	C 02/15/2018

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AVANTE AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

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F 694	Continued From page 25 give the medicine at all did you? LPN # 1 stated "No." On 2/15/18 at 3:45 pm, the surveyor spoke with the facility pharmacy manager to determine when the saline and heparin flushed were last sent to the facility for Resident # 14. The pharmacy manager informed the surveyor that the pharmacy "never" had an order for flushes for Resident # 14. The pharmacy manager stated they had received an order for IV's but no flushes. The surveyor also asked the last time the stat box had been changed in the facility and the pharmacy manager replied 2-9-18. On 2/15/18 at 5:45 pm, the administrative team was made aware of the issues as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/15/18.	F 694		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	**F 755** 1. Resident 41 received dose of Metaformin and Lantus on the afternoon of 2/14/18 when medication arrived. A 100% audit of all residents with orders for Metaformin and Lantus was conducted for past 30 days. 2. A weekly audit for residents with orders for Metaformin and Lantus will be conducted for 30 days by the DON and/or designee. 3. Inservicing initiated for nursing staff for obtaining unavailable medications that may not be readily available by pharmacy. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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F 755	Continued From page 26 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and facility document review, facility staff failed to ensure medications were available for administration to 2 residents in the survey sample (Resident #14 and 41). 1. Resident #41 was admitted to the facility on 11/3/16 with diagnoses including urinary retention, atrial fibrillation, diabetes mellitus, essential hypertension, and encephalopathy. On the most recent minimum data set assessment conducted on December 2017, the resident scored 0 on the brief interview for mental status and was assessed as having physical and verbal behaviors on 1-3 days prior to the assessment. The resident was assessed as not rejecting care. Medication Administration 02/15/18 09:27 AM During Medication pass	F 755		

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F 755	Continued From page 27 observation on 2/14/18 at 7:47 AM, Metformin and Lantus were unavailable for administration. The nurse stated both should be in the stat boxes, but neither drug was found. The Metformin arrived stat from the backup pharmacy after residents ate lunch. The nurse reported the insulin was on hold, meaning that the backup pharmacy had not delivered it.. Delivery manifests from the pharmacy were obtained. The pharmacy delivered 60 Metformin on 1/29/18. The pharmacy had not delivered enough Metformin to be administered twice per day as ordered from the delivery date until the 2/14 observation date. The medication administration record indicated the resident had refused 7 doses of Metformin during that period (enough to extend the supply 3.5 days). The pharmacy delivered 3 pens of each ordered insulin on 1/29/18. There should have been 1 open Lantus and 2 unopened, and 3 unopened regular insulin. Orders, MARs and progress notes were requested. The administrator, director of nursing and shift supervisor were notified of the concern with medication administration during a summary meeting on 2/14/18. The director of nursing stated that the resident's medications would not have run out, because the resident so frequently refused them. The surveyor offered to review the administration notes and delivery invoices from the date of order for each of the resident's medications and the offer was declined. Staff were unable to determine why the 6 insulin pens were not in the medication storage room or on the medication cart. 2. The facility staff failed to provide pharmaceutical services to ensure accurate administration of heparin and sodium chloride for	F 755		

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F 755	Continued From page 28 Resident #14. Resident # 14 is a 70-year-old female who was admitted to the facility on 7/11/17. Diagnoses included but not limited to: type 2 diabetes mellitus, lymphedema, major depressive disorder, and cellulitis of abdominal wall. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/25/17. Section C of the MDS assesses cognitive patterns. In Section C0500, Resident # 14 had a BIMS (brief interview for mental status) score of 15/15, which indicated that she was cognitively intact. According the current physician's orders that were signed and dated by the physician on 2/15/18, Resident # 14 had orders which included but were not limited to: Heparin Lock flush Solution 100 unit/ml (milliliter) Use 3 ml intravenously every shift for PICC line patency flush Qshift (every shift) using SASH (saline, antibiotic, saline, heparin) method. Sodium Chloride Flush Solution 0.9% Use 3ml intravenously every shift for PICC patency. On 2/14/18 at 8:25am, the surveyor was in Resident # 14's room speaking with her. According to Resident # 14, she was getting IV antibiotics for something she had on her leg. Resident # 14 stated that she is not currently receiving antibiotics. The surveyor asked Resident #14 to show her PICC line site. The surveyor observed a single lumen PICC line in Resident #14's right upper arm. The PICC line was unclamped and did not have a cap on the	F 755		

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F 755	Continued From page 29 end of the catheter. The PICC line dressing was worn and coming off and there was no date time or initials observed on the dressing to reflect the date changed. The surveyor asked Resident #14 when the last time he PICC line dressing had been changed and if the nurses had come in to flush he line. Resident # 14 stated not lately, not since I had that thing and pointed at the IV pump. The Surveyor looked at the empty bag that was hanging on the pole, the bag had Vancomycin 1 gram in 250 ml NS (normal saline) 0.9% and the date on the bag was 1/30/18. On 2/14/18 at 10:52 am, the surveyor observed Resident # 14's PICC line again. PICC line dressing was still coming off and the PICC line was unclamped with no cap on the end of the catheter. The surveyor asked Resident #14 if anyone had come in to flush he line. Resident #14 stated "No." On 2/14/18 at 3:42 pm, the surveyor observed Resident # 14's PICC line again. PICC line dressing was still coming off and the PICC line was unclamped with no cap on the end of the catheter. The surveyor asked Resident #14 if anyone had come in to flush he line. Resident #14 stated "No." On 2/15/18 at 9:05 am, the surveyor went in to speak with Resident # 14. The surveyor observed the PICC line in Resident #14's right arm, the surveyor observed Resident # 14's PICC line again. The PICC line dressing was still coming off and there was blood observed around the catheter insertion site. The PICC line was unclamped with no cap on the end of the catheter. The surveyor asked Resident #14 if anyone had come in to flush he line. Resident	F 755		

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F 755	Continued From page 30 #14 stated "No." Resident # 14 then stated, "I got this thing hung on my dress." If they are not going to use it, I want them to take this thing out. On 2/15/18 at 2:00 pm, the surveyor spoke with the director of nursing about the issues with Resident # 14's PICC line. The director of nursing stated that Resident # 14 has had a lot of infections and has required IV antibiotics and that was the reason for her having the PICC line. The surveyor expressed her concerns about Resident # 14 stating that her line had not been flushed or her dressing not being changed and that the PICC line was unclamped and did not have a cap on it. The surveyor requested that the director of nursing come into the room and look at the PICC line and the director of nursing complied. While in the room, the director of nursing assessed the PICC line and observed the dressing that was coming off with the bloody area and the unclamped catheter. The director of nursing stated to the surveyor that the needleless connector that was on the end of the PICC line was the cap. Resident # 14 reported to the director of nursing that she wanted the PICC line out of her arm since they were not using it. The director of nursing asked Resident #14 if she would agree to have another PICC line put in if they needed to give more antibiotic and Resident # 14 stated, "Yes." On 2/15/18 at 2:43 pm, three surveyors went in to speak with Resident # 14. While in the room Resident, # 14 showed the surveyors her PICC line site in her right arm. The surveyors observed the PICC line dressing that was coming off and blood at the insertion site. The surveyors also observed the unclamped PICC line with the uncapped needleless connector at the end. The	F 755		

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F 755	Continued From page 31 surveyors asked Resident # 14 is anyone had come in to flush her PICC line. Resident # 14 stated "No, not for a while, not since I had that thing." (While pointing to IV) The surveyors observed an empty IV bag that had Vancomycin 1 gram in 250 ml NS 0.9% that was dated 1/30/18. On 2/15/18 at 2:55pm, three surveyors spoke with LPN #1. The surveyors asked LPN # 1 if she had flushed Resident #14's PICC line today. LPN #1 stated that she had flushed the PICC line but she had only used the heparin and had not flushed with the saline yet. The surveyors asked how the medication was supposed to be administered and LPN # 1 stated, "It's supposed to be given using the SASH method. The surveyors then asked LPN # 1 if she gave the medication the way the doctor had ordered it, and LPN #1 stated "no." The surveyors asked to see where the heparin and sodium in the medication cart that was ordered for Resident # 14. LPN # 1 stated that there was not any more in the cart and that she got it from the stat box. The surveyors requested to see where she got the heparin. LPN #1 took the surveyors to a locked room where the stat box was located. LPN # 1 then stated, "It's a new box because it's all green tags." The surveyors asked to see the slip where LPN #1 had signed out the heparin. LPN # 1 stated, "I did not sign it out." LPN# 1 then looks into a cabinet in the room and removes a heparin flush and stated, "I got it from here." (Referring to the cabinet) The surveyors asked LPN # 1 where she got the medication and she stated she got it from the cabinet. The survey team stated to LPN#1 first you said you got it from the stat box, then you are saying you got it from the cabinet. You did not give the medicine at all did you? LPN # 1 stated "No."	F 755		

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F 755	Continued From page 32 On 2/15/18 at 3:45 pm, the surveyor spoke with the facility pharmacy manager to determine when the saline and heparin flushed were last sent to the facility for Resident # 14. The pharmacy manager informed the surveyor that the pharmacy "never" had an order for flushes for Resident # 14. The pharmacy manager stated they had received an order for IV's but no flushes. The surveyor also asked the last time the stat box had been changed in the facility and the pharmacy manager replied 2-9-18. On 2/15/18 at 5:45 pm, the administrative team was made aware of the issues as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/15/18.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to ensure the medication error rate was less than 5%. Medication Administration 02/14/18 09:27 AM During Medication pass observation, Metformin and Lantus were unavailable for administration. The nurse thought both should be in the stat boxes, but neither drug	F 759	**F 759** 1. Resident 41 received dose of Metformin and Lantus on the afternoon of 2/14/18. A 100% audit of all residents with orders for Metaformin and Lantus was conducted for past 30 days. 2. A weekly audit for residents with orders for Metaformin and Lantus will be conducted for 30 days by the DON and/or designee. 3. Inservicing initiated for nursing staff for obtaining unavailable medications that may not be readily available by pharmacy. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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	495156	A. BUILDING _____ B. WING _____	C 02/15/2018

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F 759	Continued From page 33 was found. The metformin arrived stat from the backup pharmacy after residents ate lunch. The nurse said the insulin was on hold. Delivery manifests from the pharmacy were obtained. The pharmacy had not delivered enough metformin to be administered as ordered from the delivery date until the 2/14 observation date. The pharmacy delivered 3 pens of each ordered insulin on 1/29/18. There should have been 1 open Lantus and 2 unopened, and 3 unopened regular insulin. Orders, MARs and progress notes were requested. The resident observed was Resident #41. Resident #41 was admitted to the facility on 11/3/16 with diagnoses including urinary retention, atrial fibrillation, diabetes mellitus, essential hypertension, and encephalopathy. On the most recent minimum data set assessment conducted on December 2017, the resident scored 0 on the brief interview for mental status and was assessed as having physical and verbal behaviors on 1-3 days prior to the assessment. The resident was assessed as not rejecting care. Medication Administration 02/15/18 09:27 AM During Medication pass observation on 2/14/18 at 7:47 AM, Metformin and Lantus were unavailable for administration. The nurse stated both should be in the stat boxes, but neither drug was found. The Metformin arrived stat from the backup pharmacy after residents ate lunch. The nurse reported the insulin was on hold, meaning that the backup pharmacy had not delivered it.. Delivery manifests from the pharmacy were obtained. The pharmacy delivered 60 Metformin on 1/29/18. The pharmacy had not delivered enough Metformin to be administered twice per day as	F 759		

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F 759	Continued From page 34 ordered from the delivery date until the 2/14 observation date. The medication administration record indicated the resident had refused 7 doses of Metformin during that period (enough to extend the supply 3.5 days). The pharmacy delivered 3 pens of each ordered insulin on 1/29/18. There should have been 1 open Lantus and 2 unopened, and 3 unopened regular insulin. The nurse notified the director of nursing that the resident's medications were not available at 8 AM on 2/14/18. The nurse then called the backup pharmacy and requested the 2 medications be sent STAT. At 10: AM on 2/14/18, the nurse reported the medications had not yet arrived. At 1:15 PM, after the resident ate lunch, the surveyor asked the nurse if the medications had been delivered. He reported that the metformin had been delivered and would be administered soon. The omission of 2 medications during medication pass observation resulted in a 5/71% error rate. The administrator, director of nursing and shift supervisor were notified of the concern with medication administration during a summary meeting on 2/14/18.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 19 residents (Resident # 20) was free of a significant	F 760	**F 760** 1. Clarification order for Finger Stick Blood Sugar (FSBS) was obtained for Resident 20 on 2/15/18. A 100% audit of all residents with orders for FSBS was conducted for past 30 days. 2. A weekly audit for residents with orders for FSBS will be conducted for 30 days by the DON and/or designee. 3. Inservicing initiated for nursing staff regarding need for clarification orders for FSBS and documented per order. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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F 760	Continued From page 35	F 760		

medication error. The facility staff failed to administer Resident #20's Novolog insulin forty-four times in January 2018 and February 2018.

The findings included:

The facility staff failed to ensure Resident #20 received scheduled insulin as ordered. Resident #20 did not receive scheduled Novolog 20 units tid (three times a day) for twenty-eight (28) times in January 2018 and sixteen (16) times in February 2018.

The clinical record of Resident #20 was reviewed 2/13/18 through 2/15/18. Resident #20 was admitted to the facility 6/13/06 and readmitted 11/8/17 with diagnoses that included but not limited to multiple sclerosis, Type 2 diabetes mellitus, acute kidney failure, urinary tract infections with extended spectrum beta lactamase, Parkinson's disease, and hypertension.

Resident #20's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/30/17 assessed the resident with a BIMS of 15/15 in Section C Cognitive Patterns. Section G Functional Status assessed Resident #20 to require extensive assistance of 2 + persons for personal hygiene. Resident #20 was totally dependent on one person for bathing. Resident #20 had functional limitations in range of motion of both lower extremities.

Resident #20's person centered care plan initiated 6/24/2012 identified the focus area that read "Resident #20 was at risk of complications

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F 760	Continued From page 36 related to DM (diabetes mellitus). Interventions: Accuchecks and insulin per MD (medical doctor) orders." The physician order dated 12/4/17 read "Novolog flexpen 20 units three times a day for DM (diabetes mellitus)." The surveyor reviewed the January 2018 and February 2018 electronic medication administration records (eMARs). Resident #20's Novolog insulin was held the following days/times; 1/1/18 8:00 a.m. blood sugar 189 < 200 Novolog held 1/1/18 11:30 a.m. Blood sugar 157 held Novolog 1/4/18 8:00 a.m. blood sugar 196. No insulin administered. 1/4/18 11:30 a.m. Blood sugar 168 No insulin administered. 1/5/18 8:00 a.m. Blood sugar 167 Insulin held 1/5/18 1630 (4:30 p.m.) Blood sugar 187 Insulin held. 1/6/18 8:00 a.m. Blood sugar 165. No insulin administered. 1/6/18 11:30 a.m. Blood sugar 173. No insulin administered. 1/7/18 11:30 a.m. Blood sugar 145. No insulin administered. 1/9/18 11:30 a.m. Blood sugar 45. Glucagon given. 1/13/18 8:00 a.m. Blood sugar 181. Insulin held. 1/13/18 1630 (4:30 p.m.) Blood sugar 62. Insulin held. 1/14/18 4:30 p.m. Blood sugar 62. Insulin held. 1/15/18 at 11:30 a.m. Blood sugar 195. No insulin administered. 1/16/18 11:30 a.m. Blood sugar 176. No insulin administered.	F 760		

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F 760	Continued From page 37 1/17/18 8:00 a.m. Blood sugar 169. No insulin administered. 1/18/18 8:00 a.m. Blood sugar 162. No insulin administered. 1/19/18 11:30 a.m. Blood sugar 159. Insulin held. 1/19/18 4:30 p.m. Blood sugar < (less than) 200. Insulin held. 1/20/18 8:00 a.m. Blood sugar 162. No insulin administered. 1/20/18 11:30 a.m. Blood sugar 185. Insulin not administered. 1/22/18 11:30 a.m. Blood sugar 188. Insulin held. 1/22/18 4:30 p.m. Blood sugar 153. Insulin held. 1/24/18 11:30 a.m. Blood sugar 86. Insulin held. 1/26/18 8:00 a.m. Blood sugar 108. Insulin held. 1/28/18 4:30 p.m. Blood sugar 95. Insulin held. 1/30/18 4:30 p.m. Blood sugar No blood sugar or insulin documented. 1/31/18 4:30 p.m. Blood sugar 82. Insulin held. 2/1/18 11:30 a.m. Blood sugar 178. No insulin administered. 2/2/18 11:30 a.m. Blood sugar 169. No insulin administered. 2/3/18 4:30 p.m. Blood sugar 142. No insulin administered. 2/4/18 11:30 a.m. Blood sugar 160. Insulin not administered. 2/4/18 4:30 p.m. blood sugar 90. Insulin held and not administered. 2/5/18 8:00 a.m. blood sugar 175. Insulin not administered. Resident refused. 2/6/18 8:00 a.m. Blood sugar 121. Insulin not administered. 2/6/18 4:30 p.m. blood sugar 132. Insulin not administered. 2/7/18 11:30 a.m. Blood sugar 129. Insulin not administered. Resident refused. 2/9/18 8:00 a.m. Blood sugar result not	F 760		

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F 760	Continued From page 38 documented. No insulin documented. 2/10/18 8:00 a.m. Blood sugar 167. Insulin held and not administered. 2/10/18 4:30 p.m. Blood sugar 102. Insulin held and not administered. 2/11/18 8:00 a.m. Blood sugar 163. Insulin held and not administered. 2/11/18 4:30 p.m. Blood sugar 149. Insulin not administered. 2/12/18 11:30 a.m. Blood sugar 98. Insulin held. 2/13/18 8:00 a.m. Blood sugar 101. Insulin held. The surveyor reviewed the January 2018 physician orders and the February 2018 physician orders and was unable to locate physician's orders to hold the insulins as listed above or that the physician had been notified the insulin had been held. Resident #20 did not have specific physician orders to hold insulin based on sliding scale. Resident #20 did not have sliding scale insulin orders. The surveyor discussed the above issue with the regional registered nurse on 2/15/18 at 2:00 p.m. The regional registered nurse stated the facility does not use standing orders. "The nurses have to call for orders." The surveyor informed the director of nursing on 2/15/18 at 3:10 p.m. of the concern with staff holding scheduled insulin without a physician order. The DON stated "I don't know if it matters but we got an order for the blood sugars and a clarification order." The surveyor requested the facility policy on diabetic management. The administrator informed the surveyor the facility does not have a policy for diabetic management on 2/15/18.	F 760		

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F 760	Continued From page 39 The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concern in the end of the day meeting on 2/15/18 at 4:44 p.m. No further information was provided prior to the exit conference on 2/15/18.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and facility document review the facility staff failed to store, prepare, and serve food under sanitary conditions in the facility kitchen. The findings included:	F 812	**F 812** 1. Hair nets and beard nets are currently worn. Food stored properly. Dishwares dried properly. Staff personal items are not stored in the kitchen. 2. Inservicing initiated for all dietary staff regarding proper storage, preparation, and serving food. 3. Weekly audits will occur for 30 days and then monthly thereafter by the Certified Dietary Manager and/or Administrator. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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F 812	Continued From page 40 On 2/13/18 at 5:00 pm, during a tour of the kitchen the surveyor accompanied by the dietary manager observed 2 containers of cereal in the dry storage area, which dietary stated what Cheerios and Rice Krispies that had been removed from its original packaging. The 2 containers that contained the cereal was undated. The dietary manager removed the containers from the dry storage area. The surveyor wearing a hairnet however, her bangs were hanging out of the front of the hair net observed the dietary manager, and hair was observed coming from the back and sides of the hair net. Dietary service worker #1 was observed wearing a hairnet, however the employee had a mustache and was not wearing a beard guard. The surveyor observed a rack containing multiple stacked pans. As one of the pans was lifted, water ran from the inside off the pan. Two more pans were lifted and water ran from the inside off the pans as well. The dietary supervisor removed the pans to have them rewashed. While reviewing the tray line the surveyor observed a pair of black eyeglasses on the soft drink rack that was next to the tray line. The surveyor asked whose glasses was on the rack. The dietary manager stated that they were (employee's name withheld) glasses and removed the glasses and took them to her office. According to the facility policy on "Staff Attire" "1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained."	F 812		

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F 812	Continued From page 41 According to the facility policy on "Manual Warewashing", "3. All serviceware and cookware will be air dried prior to storage." On 2/15/18 at 5:45 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 2/15/18.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	**F 880** 1. The Suction machine and yankauer are covered for Resident 42 and positioned on a bedside table to prevent infection. A 100% audit was conducted on all suction machines. 2. Weekly audit will be conducted for 30 days for all suction machines by the DON and/or designee. 3. Inservicing initiated regarding infection control practices and protocols for suction machines. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	3/16/18

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F 880	Continued From page 42 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility staff failed to implement infection prevention practices for 1 of 19 Residents in the survey sample, Resident # 42. The findings included: The facility staff failed to ensure that the suction catheter that was used for resident care for Resident # 42 was sanitary to help prevent the development and transmission of communicable diseases and infections. Resident # 42 is a 34-year-old-male that was admitted to the facility on 12/26/17. Diagnoses included but not limited to: fistula of the intestine, intentional self-harm by shotgun, unspecified open wound of the abdomen, anxiety disorder, and major depressive disorder. The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 1/4/18. Section C of the MDS assesses cognitive patterns. In Section C0500, Resident #42 had a BIMS (brief interview for mental status) score of 15/15, which indicated that Resident # 42 was cognitively intact. The current physician's orders for Resident # 42 was signed on 1/23/18. Resident # 42 had a current order written as "Resident may self-suction using yaunker ileostomy drainage as needed for infection control/ileostomy drainage." On 2/13/18 at 3:07 pm, the surveyor observed a suction machine with an uncovered yankauer	F 880		

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F 880	Continued From page 44 suction catheter attached on the floor bedside Resident # 42's bed. The yaunker suction catheter was touching the floor. Dried yellowish brown stool was observed on the floor near the uncovered yankauker suction catheter. On 2/14/18 at 7:59 am, the surveyor observed a suction machine with an uncovered yankauer suction catheter attached on the floor bedside Resident # 42's bed. The yaunker suction catheter was touching the floor. Dried yellowish brown stool was observed on the floor near the uncovered yankauer suction catheter. On 2/14/18 at 1:12 pm, the surveyor observed the suction machine was in the floor with the uncovered yankauer suction catheter observed on the floor and uncovered. Dried yellowish brown stool was observed on the floor near the uncovered yankauer suction catheter. Asked the resident if he minded that his catheter was uncovered. The surveyor spoke with Resident # 42 about the suction machine and catheter being in the floor. Resident # 42 stated, "That's where they put it when they brought it in here and gave it to me." "They didn't give me anything to put it on or cover the catheter up with." On 2/14/18 at 1:18 pm, the surveyor spoke with the DON (director of nursing) about the suction machine being on the floor and the suction catheter being uncovered and touching the floor. The surveyor also made the DON aware of the dried yellowish brown stool that had been observed on the floor. The DON stated "Oh no we need to elevate that and get that covered." On 2/15/18 at 10:09 am, the surveyor was in Resident # 42's room and observed the suction	F 880		

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F 880	Continued From page 45 machine still on the floor with the yankauer suction catheter uncovered and touching the floor. Dried yellowish brown stool observed on the floor near the uncovered yankauer suction catheter. According to the "Change out of Disposable Supplies" policy, the "Purpose: Prevent infection and maintain clean environment." "Monitor: Daily rounds will be done by the supervisor (Charge person) in all rooms to assure all supplies are labeled properly and changed out according to the schedule at the facility." On 2/15/18 at 5:35 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/15/18.	F 880		