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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-CHARLOTTESVILLE	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 3/7/17 through 3/9/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow.

The census in this 143 certified bed facility was 117 at the time of the survey. The survey sample consisted of twenty-one current resident reviews (Residents 1 through 21) and three closed record reviews (Residents 22 through 24).

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F 225 SS=D 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS — F 225 — April 7th, 2017

483.12(a) The facility must-

(3) Not employ or otherwise engage individuals who-

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, 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.

(4) Report to the State nurse aide registry or

.F225: Investigate/Report Allegations/Individuals

1. The Employee #1 is no longer employed with the facility.
2. BOA/designee will review 100% of current employee personnel files to Validate completion of criminal background checks.
3. BOA/designee will obtain criminal background checks for new employees prior to orientation The BOM/designee will review the employee file for new hires to validate completion Of the criminal background check prior to scheduling orientation.
4. BOA/designee will audit 10 % of the personnel file
5. of new employees monthly to validate completion of criminal background checks. Findings will be reported to the QAPI committee monthly for review and further recommendations.

Date of compliance: April 7th, 2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA — (X6) DATE: 3-24-17

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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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.

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

(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.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(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

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corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on review of facility personnel files and staff interview, the facility failed to fully screen one of five facility personnel hired within a four month period preceding the survey. The facility failed to obtain a criminal record check for a member of the dietary staff.

The findings include:

An individual hired on 12/9/16 for employment in the Dietary Department did not have a current criminal record check.

During review of the personnel file of an individual hired on 12/9/16 for the Dietary Department, it was noted there was no current criminal record check. The personnel file contained a criminal record check dated 8/18/11.

At approximately 10:00 a.m. on 3/9/17, the facility Administrator was advised the individual did not have a current criminal record check. When asked by the surveyor if the individual was a rehire, the Administrator said, "Yes," and then added that the individual was no longer employed by the facility. The Administrator said she would check again to see if there was a current criminal record check for the resident.

At approximately 10:30 a.m., the Administrator notified the surveyor that she was unable to locate a criminal record check that coincided with the employee's hire date of 12/9/16.

F 226 SS=D 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC

F 226

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F 226	Continued From page 3 POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility personnel files, facility document review, and staff interview, the facility failed to implement their policy and procedure for the screening of applicants for employment. The	F 226	April 7th, 2017 F226: Develop/Implement Abuse/Neglect, ETC Policies 1. a.) The employee #1 is no longer employed by the facility. b.)References were obtained for the employee #2 at time of hire and were not printed and placed in the chart. They have now been printed and placed in the employee's file. c.) Employee #3 is no longer employee by the facility as of 03/08/2017. 2. BOA/Designee will review 100% of the current employee files to validate completion of criminal background checks, Sworn statement attestation, and references. 3. BOA/designee will obtain criminal background checks, references and attestations for new employees prior to orientation. The ED/designee will review the employee file for new hires to validate completion of criminal background checks, References and attestation prior to scheduling orientation. BOA/Designee will audit 10% of the personnel file of new employees monthly to validate completion for criminal background checks, references, and attestations. The findings will be reported to the QAPI committee monthly for review and further recommendations.	

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facility failed to fully screen three of five facility personnel hired within a four month period preceding the survey. The facility failed to obtain a sworn statement and criminal record check for a member of the dietary staff, failed to obtain references for a member of the administrative staff, and failed to obtain a sworn statement for a Certified Nursing Assistant.

The findings include:

1. An individual hired on 12/9/16 for employment in the Dietary Department did not have a current sworn statement or a current criminal record check.

During review of the personnel file of an individual hired on 12/9/16 for the Dietary Department, it was noted there was no current sworn statement and no current criminal record check. The personnel file contained a sworn statement dated 8/1/11, and a criminal record check dated 8/18/11.

At approximately 10:00 a.m. on 3/9/17, the facility Administrator was advised the individual did not have a current sworn statement or a current criminal record check. When asked by the surveyor if the individual was a rehire, the Administrator said, "Yes," and then added that the individual was no longer employed by the facility. The Administrator said she would check again to see if there was a current sworn statement and criminal record check for the resident.

At approximately 10:30 a.m., the Administrator notified the surveyor that she was unable to locate a sworn statement or a criminal record check that coincided with the employee's hire

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date of 12/9/16.

Review of the "Screening" portion of the facility's abuse policy and procedure noted the following:

"Screening
All applicants for employment in the Company shall, at a minimum, have the following screening checks conducted:[...]
5. Criminal background check pursuant to Company policy or state law."

The Code of Virginia at Chapter 32.1-126.01, Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; notes the following, "Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal conviction or any pending criminal charges, whether within or without the Commonwealth...A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange."

2. A member of the administrative staff, hired on 1/13/17, did not have references from previous employers.

Review of the personnel file of a member of the administrative staff hired on 1/13/17 failed to reveal any references from previous employers. At approximately 10:00 a.m. on 3/9/17, the facility Administrator was advised there were no

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references in the personnel file. The Administrator said she would check to if references could be found.

At approximately 10:30 a.m., the Administrator notified the surveyor she was unable to locate any references for the employee.

"Screening
All applicants for employment in the Company shall, at a minimum, have the following screening checks conducted:[...]
1. Reference checks with the current and/or past employer.

3. A Certified Nursing Assistant (CNA), hired on 2/14/17, did not have a sworn statement.

Review of the personnel file of a CNA hired on 2/14/17 failed to reveal a sworn statement. At approximately 10:00 a.m. on 3/9/17, the facility Administrator was advised there was no sworn statement in the CNA's personnel file. The Administrator said she would check to if references could be found.

At approximately 10:30 a.m., the Administrator notified the surveyor she was unable to locate a sworn statement for the CNA.

Review of the "Screening" portion of the facility's abuse policy and procedure noted the following:

"Screening
All applicants for employment in the Company shall, at a minimum, have the following screening checks conducted:[...]
5. Criminal background check pursuant to

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F 226	Continued From page 7 Company policy or state law." The Code of Virginia at Chapter 32.1-126.01, Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; notes the following, "Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal conviction or any pending criminal charges, whether within or without the Commonwealth...A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange."	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes	F 279	F279: Develop comprehensive care plans 1. Resident #2 Comprehensive Care Plan was updated 2. to reflect cognitive loss and communication on 03/08/2017. Resident #3 Comprehensive Care Plan was updated to reflect cognitive loss, visual disturbances and behaviors on 3/8/2017. 3. RNAC/designee will review 100% of current residents last 4. Comprehensive MDS and update/validate care plans to reflect the MDS assessment. 5. The IDT team including RNACs will be educated on the care plan process and completion of updates to include cognition changes, visual disturbances, and behaviors as necessary with changes in condition of residents. 6. RNAC/designee will audit CAAs weekly x4, 7. then monthly to validate that a care plan has been updated to accurately reflect the resident's condition Findings will be reported to the QAPI committee monthly for 3 months to ensure compliance.	April 7th, 2017

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to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to 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

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requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for two of 24 residents in the survey sample, Residents #2 and #3.

The findings include:

1. Resident #2's comprehensive care plan was not developed for cognitive loss and communication.

2. Resident #3's comprehensive care plan was not developed for cognitive loss, visual disturbances and behaviors.

The findings include:

1. Resident #2's comprehensive care plan was not developed for cognitive loss and communication.

Resident #2 was originally admitted to the facility on 6/7/16 and readmitted on 12/20/16, with but not limited to, the following diagnoses: dementia with behaviors disturbances, major depression and obesity. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/3/17 was a fourteen (14) day assessment. The resident was assessed with short and long-term memory impairments and moderately impaired in decision-making skills.

A Significant change MDS with an ARD of 6/21/16 showed Section V (Care Area Assessment) of the MDS triggered the following

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areas for care planning: Cognitive Loss and Communication.

On 3/8/17 at approximately 3:00 p.m., a care plan initiated on 6/7/16 and updated on 9/12/16 was reviewed in the electronic clinical record. The care plan evidenced the areas that triggered from the MDS assessment on the care plan except for the following: Cognitive Loss and Communication.

On 3/8/17 at approximately 3:10 p.m., the administrator and the director of nursing were made aware that the following areas were not listed on the care plan. The administrator stated that the MDS coordinators would be made aware and that they would assist this Surveyor in locating the areas on the care plan.

On 3/8/17 at approximately 3:27 p.m., the MDS Coordinators, who were Registered Nurses and will be identified as RN #1 and RN #2 entered the conference room and were interviewed regarding the location of the triggered areas on the care plan. RN #1 and RN #2 reviewed the care plan in the electronic clinical record with this Surveyor. RN #1 was interviewed regarding the triggered areas and the location on the care plan. RN #1 stated, "I don't see it." When interviewed and asked if a care plan should have been initiated for the triggered areas, RN #1 stated, "Yes."

On 3/9/17 at approximately 9:45 a.m., an updated copy of the care plan dated 3/8/17 was provided to this Surveyor to include cognitive loss and communication. The administrator stated, "The care plan was fixed to include the missing areas."

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2. Resident #3 had no care plan developed regarding cognitive impairment, vision and behaviors.

Resident #3 was admitted to the facility on 7/25/16 with diagnoses that included dementia, vitamin deficiencies, glaucoma, arthritis and depression. The minimum data set (MDS) dated 2/20/17 assessed Resident #3 with severely impaired cognitive skills.

Resident #3's MDS assessment completed on 8/23/16 due to a significant change in condition included cognitive impairment, vision problems and behaviors among the list of care assessment areas requiring the development of a comprehensive care plan. The care area assessment summary indicated these areas were supposed to be included in the resident's plan of care.

Resident #3's plan of care (revised 2/21/17) included no problems, goals and/or interventions addressing the resident's impaired cognition, impaired vision or behaviors.

On 3/8/17 at 2:00 p.m. the registered nurse (RN #1) responsible for care plan development was interviewed about the missing items for Resident #3. After reviewing the care plan, RN #1 stated she did not see anything on the care plan about cognition, vision or behaviors. RN #1 stated, "I don't see anything on the care plan about any of those three things [cognition, vision, behaviors]."

These findings were reviewed with the administrator and director of nursing during a meeting on 3/8/17 at 3:30 p.m.

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F 280 SS=D	Continued From page 12 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280 F 280		April 7th, 2017

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

F280: Right to Participate Planning Care-Revise CP
1. Resident #14 and Resident #19 continue to reside at the facility.
Resident #14 care plan was updated on 3/8/17
to reflect current cognitive status/current BIM score.
Resident #19's care plan was updated on 3/21/17
to reflect current bed mobility status and transfer skills.
2. Current residents with a change in cognition and
or change in physical functioning in the past 30 days
will be reviewed by the ID team and care plans
will be updated as indicated
3. Licensed Nurses and IDT team will be educated
on the RAI process for review and revision of care plans
4. The DNS/designee will do random audits of care plans and
care plan meetings monthly to ensure that changes in cognition
and physical functioning are accurately reflected in the plan of care.
Findings will be reported to QAPI committee monthly
for 3 months to ensure compliance.

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(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

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

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

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

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the

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comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed, for two of 24 residents in the survey sample (Residents # 14 and 19), to update the residents' plan of care.

1. Resident # 14's plan of care was not updated to reflect a change in cognitive status.

2. Resident # 19's plan of care was not updated to reflect a change in bed mobility and transfer skills.

The findings include:

1. Resident # 14's plan of care was not updated to reflect a change in cognitive status.

Resident # 14 in the survey sample, an 80 year-old male, was admitted to the facility on 4/14/16, and most recently readmitted on 10/13/16 with diagnoses that included left and right femur fractures, cellulitis, alcohol dependence, malignant neoplasm of the prostate, encephalopathy, hearing loss, epilepsy, and cerebral ataxia. According to a Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/20/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 5 out of 15.

According to the most recent Quarterly MDS with an ARD of 1/18/17, the resident was assessed under Section C (Cognitive Patterns) as having

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improved to being cognitively intact, with a Summary Score of 14 out of 15.

Resident # 14's care plan, dated 10/13/16, and updated 1/22/17, included the following problem, "Impaired cognitive status related to: BIMS (Brief Interview for Mental Status) score of 6."

It should be noted that the last time Resident # 14's cognitive status summary (BIMS) score of "6" was on a Medicare 14-Day MDS with an ARD of 4/28/16.

During a meeting at 4:00 p.m. on 3/8/17 that included the Administrator, Director of Nursing, and the survey team, the failure to update the resident's care plan to match his improved cognitive status was discussed.

2. Resident # 19's plan of care was not updated to reflect a change in bed mobility and transfer skills.

Resident # 19 in the survey sample, a 62 year-old male, was admitted to the facility on 6/25/16 with diagnoses that included sepsis, polyosteoarthritis, hypertension, hypernatremia, diabetes insipidus, chronic gout, and chronic venous insufficiency. According to a Medicare 5-Day MDS with an ARD of 7/2/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Under Section G (Functional Status), the resident was assessed as needing extensive assistance with two persons physical assist for bed mobility and transfers.

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According to the most recent Quarterly MDS with an ARD of 12/29/16, the resident's cognitive status under Section C (Cognitive Patterns) was unchanged. Under Section G (Functional Status), the resident was assessed as having improved to needing only supervision with one person physical assist for bed mobility and transfers.

Resident # 19's care plan, dated 6/27/16, and updated on 1/3/17, included the following problem, "I have a physical functioning deficit related to: Mobility impairment." The goal for the problem was, "I will improve my current level of physical functioning."

The approaches to the stated problem included. "Bed mobility assistance of 2; Transfer assistance of 2." The updated care plan did not reflect the Resident # 19's improvement in bed mobility and transfer skills.

F 309 SS=E — 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to

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facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to follow physician orders for two of 24 residents in the survey sample.

1. For over two months, Resident #1 had no daily monitoring of her fluid intake to ensure compliance with a physician's order requiring the resident to have no more than 2 liters of fluid per day.

2. Resident #5 was observed without physician ordered protective "geri-sleeves" in use.

The findings include:

F309: Provide Care/Services for the highest well being
1. Resident #1 continues to reside at the facility.
2. Daily fluid intake monitoring was added to resident #1's Physician orders, meal ticket and care card on 3/8/17 to ensure compliance with physician order to have no more than two liters of fluid per day.
Resident #5 continues to reside at the facility.
Resident #5's Geri-sleeves were immediately obtained from laundry and placed on resident per physician order.
The DNS/designee has reviewed 100% of the medical records of residents on fluid restrictions and residents that wear geri-sleeves to ensure physician ordered interventions are in place.
The DNS/designee will provide education for the nursing staff regarding the standards of practice for following physician ordered fluid restrictions and geri-sleeves.
The IDT team will review new orders during morning start up meeting.
3.The DNS/designee will audit 100% of medical records of residents on fluid restrictions and geri-sleeves monthly to validate adherence to the standards of practice for following physician orders.
Findings will be reported to the QAPI committee monthly for 3 months to ensure compliance.

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1. For over two months, Resident #1 had no daily monitoring of her fluid intake to ensure compliance with a physician's order requiring the resident to have no more than 2 liters of fluid per day.

Resident #1 was admitted to the facility on 7/16/10 with a re-admission on 1/2/17. Diagnoses for Resident #1 included congestive heart failure, dementia with behaviors, psychosis, depression and anxiety. The minimum data set (MDS) dated 2/1/17 assessed Resident #1 with short and long-term memory problems and severely impaired cognitive skills.

Resident #1's clinical record documented a physician's order dated 1/2/17 requiring "Fluid Restriction" stating the resident was to have no more than 2 liters of fluid per day for management of congestive heart failure. The resident's plan of care (revised 2/6/17) listed the resident had a history of fluid retention with an impaired cardiovascular condition. Interventions to prevent decline in cardiac functioning included, "fluid restriction as ordered."

Resident #1's clinical record from 1/2/17 through 3/7/17 included no tracking and/or summary of the resident's daily fluid intake. The resident's treatment records listed the fluid restriction but there was no documentation of the resident's actual fluid intake amounts. Meal intake records recorded percentages of each meal eaten by the resident but did not record the actual amount of fluid intake by day.

On 3/8/17 at 9:45 a.m. the licensed practical nurse (LPN #1) caring for Resident #1 was

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interviewed about Resident #1's fluid restriction. LPN #1 stated the resident's fluid intake "was not anywhere in the computer." LPN #1 stated at the end of her shift she wrote on the shift report what drinks/fluids she gave the resident. LPN #1 stated she only wrote down the fluids she administered and stated she did not keep up other fluid intake the resident had during the day. LPN #1 stated, "I just write down what I give her. I don't know what else is given." LPN #1 stated the fluid amounts she gave the resident were not part of the clinical record but were on a shift report.

On 3/8/17 at 9:47 a.m. the certified nurses' aide (CNA #1) routinely caring for Resident #1 was interviewed about the fluid restriction and any tracking of the resident's fluid intake. CNA #1 stated the resident kept a water pitcher at her bedside, got ginger ale with her lunch and was given several nutritional drinks during the day. CNA #1 stated she was not writing down any amounts for drinks or fluids given the resident. CNA #1 stated she only recorded the resident's meal and/or snack intake in percentages.

On 3/8/17 at 3:35 p.m. the director of nursing (DON) was interviewed about any tracking of Resident #1's fluid intake to ensure compliance with the physician ordered fluid restriction. The DON stated the treatment records were signed off each shift but there were no actual amounts of fluid intake recorded for the resident. The DON stated the resident's fluid intake was not tracked or summarized daily.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/8/17 at 3:30 p.m.

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2. Facility staff failed to ensure physician ordered geri-sleeves were in place for Resident #5.

Findings were:

Resident #5 was originally admitted to the facility on 10/25/2012. Her diagnoses included but were not limited to: Pain, depressive disorder Pressure ulcers, cerebral infarction, and urine retention.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/17/2016. Resident #5 was assessed as having problems with both long and short term memory, as well as being severely impaired with daily decision making skills.

The electronic clinical record was reviewed on 03/08/2017. The following order was observed on the physician order sheet: "Gerisleeves to BUE [bilateral upper extremities] q [every] shift every shift for maintain skin integrity on bil [bilateral] upper extremities."

On 03/08/2017 at approximately 11:00 a.m., this surveyor went to Resident #5's room with the unit manager to see if her geri-sleeves were in place. He pulled back the covers and stated, "No, they are not there. They may be in the laundry...I will talk to her CNA [certified nursing assistant]."

At approximately 1:00 p.m., CNA #1 was interviewed regarding Resident #5's geri-sleeves. She stated, "I checked her first thing...I like to check on her first because her skin is so fragile...that place on her elbow had leaked on it

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F 309	Continued From page 21 so I took them off to go to the laundry. She normally has a tan pair in there in the drawer and they are interchangeable but they weren't in there...I took the dirty ones to laundry...when I got back up here I got sidetracked and I forgot about them." The DON (director of nursing) and the administrator were notified of the above information during an end of the day meeting on 03/08/2017. No further information was obtained prior to the exit conference on 03/09/2017.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		

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F 323	Continued From page 22 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure an adaptive call bell system was accessible for one of 24 residents in the survey sample. Resident #11, totally dependent upon staff for transfers and mobility, was left in her wheelchair in her room for approximately 5 hours without access to her adaptive "puffer" call bell. The findings include: Resident #11 was admitted to the facility on 5/8/13 with a re-admission on 2/13/17. Diagnoses for Resident #11 included multiple sclerosis, anxiety, urinary tract infection, depression and status/post surgical debridement of abscess. The minimum data set (MDS) dated 2/20/17 assessed Resident #11 as cognitively intact. This MDS assessed Resident #11 as totally dependent upon two people for bed mobility and transfers. A facility reported incident form dated 6/21/16 documented Resident #11 reported she was left up in her wheelchair on 6/17/16 from 10:00 p.m. until 3:00 a.m. without staff checking on the her and without access to her adaptive "puffer" call system. The facility's investigation stated, "On Friday, June 17th and the morning of Saturday June 18th [2016] resident [#11] was not put to bed and left in her power wheelchair until early morning. Resident had no noted injuries.	F 323	Past noncompliance: no plan of correction required.	

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Resident's skin was intact and she was placed in bed..." The investigation stated the evening of the incident the resident's routine certified nurses' aide (CNA #2) placed her mouth/breath activated "puffer" call light on the resident's headboard out of the resident's reach when preparing the resident for bed. CNA #2 left the room and when she returned to put Resident #11 to bed, licensed practical nurse (LPN) #3 was administering medications to the resident. CNA #2 left work at 10:00 p.m. as scheduled. The investigation stated, "Following the treatment, [LPN #3] left the room and closed the door as the resident prefers to have her door closed at all times. The arriving C.N.A. [CNA #3] presumed that resident was in bed as the door was closed. Resident remained in her chair and away from her call bell until sometime between 3 am and 4:45 a.m. According to the oncoming C.N.A. [CNA #3], she entered the resident's room at 3 a.m. Resident was immediately placed into bed and assessed and provide with ADL [activity of daily living] care..." The report stated LPN #3 was the last to leave Resident #11's room that evening and "failed to ensure that resident was put to bed...We have contacted the agency and requested that [LPN #3] not return to our center. C.N.A. [CNA #3] has received a corrective action for failing to complete her rounds before leaving her assignment. We have provided additional inservice education on shift change communication and rounding every two hours..." A documented interview with CNA #3 stated, "... [CNA #3] stated she was busy doing rounds and 'did not know why she hadn't went in to [Resident #11's] room on rounds. [CNA #3] stated that she went in around 3 a.m. when she heard [Resident #11] yelling and noted that she was still in her chair." (sic)

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On 3/7/17 at 2:30 p.m. Resident #11 was interviewed about the incident on 6/17/16. Resident #11 stated she usually stayed up in her wheelchair until around 10:00 p.m. Resident #11 stated on the evening of 6/17/16 a nurse came in and gave her a prescribed injection. Resident #11 stated her call bell "puffer" had been placed on the table out of her reach by the CNA while getting her ready for bed. Resident #11 stated the nurse gave her the injection and did not come back to put her to bed. Resident #11 stated she is very soft spoken and tried to yell out but was not heard. Resident #11 stated her adaptive call bell was not within her reach. Resident #11 stated she was unable to use a standard call bell due to her disease process and required an adaptive call system that she activated with puffs of air blown into a mounted tube. Resident #11 stated she stayed in her wheelchair until a CNA finally heard her yell out around 3:30 a.m. Resident #11 stated her call bell was out of reach and no staff members came in to check on her from 10:00 p.m. when the nurse left until around 3:30 a.m. when the aide heard her yell.

The resident's plan of care in place at the time of the incident on 6/17/16 listed the resident had a physical functioning deficit and impaired mobility due to her multiple sclerosis. The care plan stated, "...dependent on staff for all aspects of care...Resident uses modified call system..." Interventions to address physical functioning deficits included, "...use of modified call bell system (sip/puff)...aides to round on pt [patient] at beginning and end of shift on 11-7, then prn [as needed] at pt request..."

On 3/8/17 at 10:00 a.m. the registered nurse unit

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	495153	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-CHARLOTTESVILLE	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

(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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manager (RN #3) was interviewed about the resident left without access to her call bell on 6/17/16. RN #3 stated, "The incident happened." RN #3 stated corrective actions had been taken since the incident to prevent this from happening again or to someone else. RN #3 stated the resident was left up for about 5 hours without access to her call light.

On 3/8/17 at 11:00 a.m. the director of nursing (DON) was interviewed about Resident #11 being left in her wheelchair without call bell access. The DON stated on the evening of 6/17/17, LPN #3 gave the resident her prescribed injection but did not give an ordered suppository because the resident was not in bed. The DON stated CNA #3 had previously started getting the resident ready for bed and moved the "puffer" call bell to the bed and was waiting for the nurse to finish with the injection. The DON stated CNA #3 left as scheduled at 10:00 p.m. that evening. The DON stated LPN #3 failed to communicate to the next shift that the resident had not been put to bed. The DON stated the resident usually got her suppository when put to bed around 10:00 p.m. and then would ring her call bell when ready for the aides to clean her. The DON stated the resident did not ring for the CNA because the call light was not accessible and the oncoming nurses on the 11:00 p.m. to 7:00 a.m. shift failed to check on the resident until around 3:00 a.m. The DON stated the night shift CNA was waiting for the resident to ring her call bell and she never did. The DON stated the resident was very regimented with her nightly routine and usually let the CNA's know when she was ready to go to bed or when she needed personal care. The DON stated the resident preferred her door to stay closed all the time. The DON stated the 11 to 7

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shift aide thought the resident was already in bed but should have checked on the resident anyway and made sure her call bell was accessible. The DON stated LPN #3 should have communicated to the oncoming shift that Resident #11 needed to be assisted to bed. The DON stated the LPN and aide on the 11:00 p.m. to 7:00 a.m. shift on that morning had no explanation of why they did not check on the resident. The DON stated she expected nurses and aides to ensure call bells were accessible for all residents and to check on residents at least every two hours or more often if needed.

On 3/8/17 at 3:30 p.m. the DON stated the facility had recognized the failure with leaving Resident #11 in her chair without call bell access in June 2016 and had developed and implemented a corrective action plan in response to the incident. The facility's plan of corrective included the following.

1. Resident #11 was provided with immediately care once discovered on 6/18/16 and her adaptive call bell was mounted for access by the resident.
2. An audit of all residents was conducted for call bell placement, focusing on residents that chose to keep their doors closed.
3. Inservice education was provided to all nurses and aides addressing requirement for residents to have a call bell accessible at all times and for nurses and aides to check on all residents at least every 2 hours or as needed. All new residents wanting to keep their door shut were discussed in the daily morning meeting and care plans and care cards updated. Two hours checks were documented for Resident #11 for at least a month following the incident to ensure

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compliance with expectations.
4. The DON conducted audits three times per week for 3 weeks following the inservice education to ensure accessible call bells and that care plans and care cards were updated to accurately reflect residents that routinely kept their doors closed. Data collected was discussed in morning meetings and quality assurance meetings.

The DON stated the correction plan regarding the call bell access was completed on 8/2/16.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/8/17 at 3:30 p.m.

This deficiency was cited as past non-compliance as there were no findings during the current survey indicating lack of call bell access for residents and/or inadequate supervision/devices to prevent accidents.

F 332 SS=D 483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE F 332

(f) Medication Errors. The facility must ensure that its-

(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on medication pass and pour observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than five percent.

There were 31 opportunities and two medications

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not available for administration, during a medication pass and pour observation on 03/08/2017, resulting in a medication error rate of 6.45 percent.

Findings were:

A medication pass and pour observation was conducted on 03/08/2017 beginning at approximately 8:20 a.m. with LPN (licensed practical nurse) # 1.

LPN # 1 prepared medications for Resident #17. Resident #17 was originally admitted to the facility on 10/07/2016. Her diagnoses included but were not limited to: Hypertension, adult failure to thrive, blindness, and dementia.

Her most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/12/2017. Resident #7 was assessed as having a cognitive summary score of "07", indicating severe impairment with her cognitive status.

During the preparation of the medications, LPN # 1 was observed looking through the drawers, picking up multiple bottles and looking at the labels. She stated, "I am looking for her Vitamin B 12....I don't see what she has ordered...we have 500 mcg but she is ordered 100 [mcg]." LPN # 1 prepared the rest of the medications available and gave them to Resident #17.

When this surveyor reconciled the medications given with the orders written in the electronic record an order was observed for: "Dorzolamide HCL Solution 2% Instill 1 drop in left eye one time a day for glaucoma". Dorzolamide had not

F332: Free of medication error rates of 5% or more
1. Resident #17s eye drops were re-ordered on 3/8/17 and they arrived that night.
A physician order was obtained on 3/8/17 to hold the medication until it arrives.
The eye drops arrived and were administered per order on 3/9/17.
The physician was notified and gave an order to change vitamin B12 to 500mg q day.
The order was transcribed and the medication was given to resident.
The nurse was educated on proper administration of medications.
2. An audit of current residents physician ordered medications was completed to ensure medication availability.
3. DNS/designee will educate licensed nurses on proper medication administration and procedure for obtaining medications from pharmacy.
4. The DNS/designee will complete random medication administration Observations weekly for 2 weeks and then monthly for 3 months to ensure nurses are administering medications per physician order.
Findings will be reported to QAPI committee monthly for 3 months to ensure compliance.

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been observed as given during the medication pass and pour.

LPN # 1 was interviewed at approximately 10:30 a.m., regarding the medications ordered for 9:00 a.m. and not given. (Vitamin B 12 and Dorzolamide). She stated, "I called the doctor to see what they want to do about the B 12...we have 500 mcg here but not 100 mcg...I don't know if she had a card from the pharmacy for that or what...I ordered the Dorzolamide from the pharmacy. I got an order to put it on hold until it can get here." LPN # 1 was asked when the medicine would arrive from the pharmacy. She stated, "Sometime tonight...she will start getting it again tomorrow." LPN # 1 was asked when medications were normally ordered. She sated, "When we get low they should order them."

The DON (director of nursing) and the administrator were notified of the above information on 03/08/2017 at approximately 1:30 p.m.

During an end of the day meeting the DON presented a new order for the Vitamin B12. The new order was for Vitamin B 12 500 mcg one time a day for supplement.

On 03/09/2017 at approximately 10:15 a.m., the DON stated that the eye drops had arrived from the pharmacy and had been given that morning (03/09/2017).

No further information was obtained prior to the exit conference on 03/09/2017.

F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	

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(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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced by:
Based on medication pass and pour observation, staff interview and clinical record review, the facility staff failed to ensure two medications were available for administration.

Two medications were not available for administration during a medication pass and pour observation on 03/08/2017, Vitamin B 12 and Dorzolamide.

Findings were:

A medication pass and pour observation was conducted on 03/08/2017 beginning at approximately 8:20 a.m. with LPN (licensed practical nurse) # 1.

LPN # 1 prepared medications for Resident #17. Resident #17 was originally admitted to the facility on 10/07/2016. Her diagnoses included but were not limited to: Hypertension, adult failure to thrive, blindness, and dementia.

Her most recent MDS (minimum data set) was a

F425 Pharmaceutical Services Accurate Procedures, RPH
1. Resident #17 eye drops were re-ordered on 3/8/17 and they arrived the same night.
The eye drops were given the following morning as ordered.
There was a physician order to hold the medication on 3/8/17.
The physician was notified regarding the B12 medication
and gave a telephone order to DC the B12 100mcg and start B12 500mcg.
2. An audit of current residents physician ordered medications
was completed to ensure medication availability.
3. DNS/designee will educate licensed nurses on proper medication administration
and procedure for obtaining medications from pharmacy
4. The DNS/Designee will complete random medication administration observations
weekly for two weeks and then monthly for 3 months
to ensure nurses are administering medications per physician order.
Unit managers will audit 5 residents weekly to ensure all medications are available
and have been re-ordered per policy.
Findings will be reported to QAPI committee monthly
for review and recommendations.

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quarterly assessment with an ARD (assessment reference date) of 01/12/2017. Resident #7 was assessed as having a cognitive summary score of "07", indicating severe impairment with her cognitive status.

During the preparation of the medications, LPN # 1 was observed looking through the drawers, picking up multiple bottles and looking at the labels. She stated, "I am looking for her Vitamin B 12....I don't see what she has ordered...we have 500 mcg but she is ordered 100 [mcg]." LPN # 1 prepared the rest of the medications available and gave them to Resident #17.

When this surveyor reconciled the medications given with the orders written in the electronic record an order was observed for: "Dorzolamide HCL 2% Instill 1 gtt drop in left eye one time a day for glaucoma. Dorzolamide had not been observed as given during the medication pass and pour.

LPN # 1 was interviewed at approximately 10:30 a.m., regarding the medications ordered for 9:00 a.m. and not given. (Vitamin B 12 and Dorzolamide). She stated, "I called the doctor to see what they want to do about the B 12...we have 500 mcg here but not 100 mcg...I don't know if she had a card from the pharmacy for that or what...I ordered the Dorzolamide from the pharmacy. I got an order to put it on hold until it can get here." LPN # 1 was asked when the medicine would arrive from the pharmacy. She stated, "Sometime tonight...she will start getting it again tomorrow." LPN # 1 was asked when medications were normally ordered. She sated, "When we get low they should order them."

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

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The DON (director of nursing) and the administrator were notified of the above information on 03/08/2017 at approximately 1:30 p.m.

During an end of the day meeting the DON presented a new order for the Vitamin B 12. The new order was for Vitamin B 12 500 mcg one time a day for supplement.

On 03/09/2017 at approximately 10:15 a.m., the DON reported that the eye drops had arrived from the pharmacy and had been given that morning (03/09/2017).

No further information was obtained prior to the exit conference on 03/09/2017.