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COLONNADES HEALTH CARE CENTER	100 COLONNADES HILL DRIVE CHARLOTTESVILLE, VA 22901

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/16/18 through 1/18/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 01/16/2018 through 01/18/2018. The facility was not substantial compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaints was investigated. The Life Safety Code survey/report will follow. The census in this 32 certified bed facility was 22 at the time of the survey. The survey sample consisted of 19 total Resident reviews, including closed and current residents.	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		

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

SNA 2/6/18

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

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(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 and clinical record review, the facility staff failed to develop comprehensive care plan for one of 19 residents, Resident #276 (R 276). This was a closed record review.

R 276 did not have a comprehensive care plan to include cognitive concerns or ambulation.

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Findings include:

R 276 was admitted to the facility on 11/22/17 with diagnoses lack of coordination, difficulty walking, and traumatic subarchnoid hemorrhage (internal head bleed) resulting from a fall prior to admission.

The most recent MDS (minimum data set) was an initial with an ARD (assessment reference date) of 11/26/17. R 276 was assessed with a cognitive status of having short-term memory loss and moderately impaired with daily decision making skills.

R 276's electronic record was reviewed on 1/18/18 and evidenced, via comprehensive MDS dated 11/26/18, section "C" (cognitive patterns) that R 276 was coded as having short-term memory loss and was moderately impaired in daily decision making skills that required supervision. Under section "G" (functional status), R 276 was coded as needing physical assistance with locomotion on and off the unit.

Review of R 276's progress notes documented that R 276 was confused at times. A progress note dated 11/23/17 indicated that R 276 was newly diagnosed with dementia and sundowners syndrome after a visit to the emergency department for confusion and dilated pupils. There was no other documentation to confirm this diagnoses found in the record.

Review of physical therapy notes indicated that therapy was working with R 276 on strength training that included walking with a walker and supervision.

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F 655	Continued From page 3 On 1/18/18 at 9:30 a.m. the MDS coordinator (registered nurse, RN #3) was interviewed concerning R 276's care plan. After reviewing the information presented to RN #3, RN #3 verbalized that a care plan for cognition and how R 276 will ambulate should have been care planned. On 1/18/18 at 10:15 a.m. The director of nursing (DON) was informed of the above finding. The DON verbalized that she did not realize that R 276 was confused at times, she (DON) verbalized that it was not reported to her regarding R 276 being disoriented. The DON also verbalized that R 276 should have been supervised when ambulating. No further information was presented prior to exit conference on 1/18/18.	F 655		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on, staff interview and clinical record review, and facility document review, the facility staff failed to provide supervision to prevent a fall with injury resulting in harm for one of 19 residents, Resident #276 (R 276). This was a closed record review and a facility reported	F 689		

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incident.

R 276 left the facility without staff knowing, fell on the sidewalk and fractured the maxillary sinus and right occipital bone (facial, and head bones)

Findings include:

R 276 was admitted to the facility on 11/22/17 with diagnoses lack of coordination, difficulty walking, and traumatic subarachnoid hemorrhage (internal head bleed).

The most recent MDS (minimum data set) was an initial with an ARD (assessment reference date) of 11/26/17. R 276 was assessed with a cognitive status of having short-term memory loss and moderately impaired daily decision making skills.

R 276's electronic record was reviewed on 1/18/18 and evidenced, via progress notes dated 11/26/17 (time stamped 11:00 a.m.) that R 276 became agitated, aggressive and uncooperative with staff prior to breakfast, R 276 refused to use the wheelchair and insisted to ambulate with a cane to the dining room for breakfast.

Another progress noted dated 11/26/17 (time stamped 12:00), documented that R 276 was observed lying face down on the in the parking lot and complaining of facial and knee pain and that the facilities staff had been notified by assisted living staff personal who had been notified by a vendor. At this time emergency services were called and R 276 was sent to the hospital.

A late entry progress note dated 11/26/17 (time stamped 4:30 p.m.) summarized the event that

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took place earlier with R 276. The progress note evidenced that R 276 was observed standing in the hallway with a cane and was unsteady, with anxious body language, verbalizing that medications were not given the day prior to the incident and documents that R 276 has confusion. Documentation also indicates (the evening prior to the incident) that R 276 refused to sit in wheelchair, saying that she (R 276) has been using a cane for years, the staff were unable to redirect R 276 and the staff observed R 276 ambulating unassisted with repeated attempts to redirect.

Review of R 276's admission evaluation (titled Service Evaluation and Health Assessment) dated 11/22/17 indicated (under section Fall Care Plan) that R 276 had confusion and used an assistive device. The evaluation documented (under the section for walking) that ambulation was not evaluated at the time of the evaluation. The evaluation also indicated that R 276 was not an elopement risk.

Review of R 276's comprehensive MDS dated 11/26/18, section "C" (cognitive patterns) that R 276 was coded as having short-term memory loss and was moderately impaired in daily decision making skills that required supervision. Under section "G" (functional status), R 276 was coded as needing physical assistance with locomotion on and off the unit.

Review of R 276's progress notes documented that R 276 was confused at times. A progress note dated 11/23/17 indicated that R 276 was newly diagnosed with dementia and sundowners syndrome after a visit to the emergency department for confusion and dilated pupils.

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There was no other documentation to confirm this diagnoses found in the record.

Review of physical therapy notes indicated that therapy was working with R 276 on strength training that included walking with a walker with supervision.

Review of R 276's care plan did not evidence a care plan related to cognition or interventions for ambulation or devices used for ambulation/locomotion.

Review of the facilities investigation surrounding the incident documented that R 276 refused to use a wheel chair, insisted on using a cane, was agitated and aggressive towards staff and was not easily redirected. The investigation indicated that R 276 was observed sitting in a common area at 11:00 a.m. on 11/26/17 and was found outside by a vendor driving a truck and had been sitting in the truck for 10 minutes (R 276 was found when the driver got out of his truck at 11:35 a.m.). The investigation did not evidence that any staff person observed R 276 leave the facility.

On 1/18/18 at 9:00 a.m. rehab tech (other staff, OS #11) was interviewed. OS #11 was asked how therapy communicates information to nursing staff regarding how a resident uses a device for locomotion/ambulation while at the facility. OS #11 verbalized that after an evaluation is completed an order is written and/or a verbal conversation between therapy and nursing staff communicates how or what device is used when ambulating or transferring a resident. Documentation of R 276's communication between therapy and nursing staff was not seen by this surveyor.

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On 1/18/18 at 9:30 a.m. the MDS coordinator (registered nurse, RN #3) was interviewed concerning R 276's care plan. After reviewing the information presented to RN #3, RN #3 verbalized that a care plan for cognition and how R 276 will ambulate should have been care planned.

On 1/18/18 at 10:15 a.m. The director of nursing (DON) was informed of the above finding. The DON verbalized that she did not realize that R 276 was confused at times, she (DON) verbalized that it was not reported to her regarding R 276 being disoriented. The DON verbalized that the care plan was an oversight and should have been updated and feels that R 276 was unsupervised at the time of the fall and she should have been supervised.

No further information was presented prior to exit conference on 1/18/18.

F 697 SS=E Pain Management
CFR(s): 483.25(k)

F 697

§483.25(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.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to perform assessments and attempt non-drug interventions regarding pain for two of 19 residents in the survey sample. Resident #11 and

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Resident #20 were administered multiple doses of as needed pain medication without documented assessments or prior attempts at non-pharmacological interventions for pain reduction.

The findings include:

1. Resident #11 was administered 16 doses of the pain medication Hydromorphone without documented assessments or prior attempts of non-drug interventions for pain reduction.

Resident #11 was admitted to the facility on 12/19/17 with diagnoses that included left femur fracture, hypertension, depression, anemia, hypothyroidism, diabetes and osteoarthritis. The minimum data set (MDS) dated 12/26/17 assessed Resident #11 as cognitively intact.

Resident #11's clinical record documented a physician's order dated 12/20/17 for the medication Hydromorphone 2 mg (milligrams) to be administered every four hours as needed for pain.

Resident #11's medication administration record (MAR) documented as needed doses of Hydromorphone were administered on the following dates/times:

1/1/18 at 8:34 p.m.
1/3/18 at 7:43 p.m.
1/3/18 at 11:07 a.m.
1/4/18 at 6:16 p.m.
1/5/18 at 1:09 a.m.
1/5/18 at 9:37 a.m.
1/8/18 at 9:19 p.m.
1/9/18 at 11:58 a.m.

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1/9/18 at 8:09 p.m.
1/12/18 at 10:15 a.m.
1/12/18 at 9:21 p.m.
1/13/18 at 12:29 a.m.
1/14/18 at 8:00 a.m.
1/14/18 at 8:08 p.m.
1/15/18 at 11:46 a.m.
1/15/18 at 9:15 p.m.

There were no documented assessments for these doses of Hydromorphone indicating the location or type of pain. Only three of the 16 doses had a documented pain rating from the resident from a scale with zero indicating no pain and 10 indicating their worst pain. There were no attempts of any non-pharmacological interventions for pain reduction listed for any of these administered doses.

Resident #11's plan of care (revised 1/5/18) documented the resident was at risk of pain due to a left femur fracture, diabetic neuropathy and tongue pain. Interventions to minimize pain included medications (Tylenol and Hydromorphone), ice packs with towel barrier, repositioning, recreational activities, topical gel for osteoarthritis, oral Lidocaine solution for mouth pain and "Observe/report/document any complaint of pain and or requests for pain medication."

On 1/17/18 at 8:57 a.m., the licensed practical nurse (LPN #1) caring for Resident #11 was interviewed about pain assessments associated with the administered Hydromorphone. LPN #1 stated the notes listed in the clinical record were automatically entered from the MAR system when the medications were administered. LPN #1 stated there was space in the MAR system to

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enter custom notes about the location, pain rating and any non-drug interventions. LPN #1 stated Resident #11 at times elevated her left leg to minimize pain and swelling. LPN #1 stated the pain location, pain rating and type of pain should be entered in the record when as needed pain medication was given.

On 1/17/18 at 2:14 p.m., the director of nursing (DON) was interviewed about assessments for pain and non-drug interventions. The DON stated nurses were supposed to enter a note in the clinical record indicating the location, type of pain and a pain rating when as needed pain medication was administered. The DON stated their MAR system provided a space for customized notes. The DON stated any non-drug interventions offered or attempted should also be listed in the clinical record.

The facility's policy titled Pain Management Program stated concerning administration of as needed (prn) pain medication, "When analgesic medication is administered in response to an episode of pain, the licensed nurse or Medication Care Manager documents the evaluation, treatment, and the effectiveness of the treatment... The following is documented: Date and time... Pain rating...Non-pharmacological treatments provided... Location of pain... Medication name and dose... Administering nurse..."

The Nursing 2017 Drug Handbook on page 734 describes Hydromorphone as an opioid analgesic used for the treatment of moderate to severe pain. Page 736 of this reference states Hydromorphone has a black box warning stating, "Hydromorphone is an opioid agonist with an

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abuse liability similar to other opioid agonists... Use with ethanol, other opioids, and other CNS [central nervous system] depressants can increase risk of adverse events..." This reference lists adverse reactions include sedation with doses adjusted and used with caution in the elderly. (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 1/17/18 at 4:45 p.m.

2. Resident #20 was administered nine doses of the pain medication Oxycodone without documented assessments or prior attempts of non-drug interventions for pain reduction.

Resident #20 was admitted to the facility on 12/23/17 with diagnoses that included status post left hip replacement, depression, osteoporosis, fracture, osteoarthritis, glaucoma and cellulitis. The minimum data set (MDS) dated 12/30/17 assessed Resident #20 as cognitively intact.

Resident #20's clinical record documented a physician's order dated 12/23/17 for the medication Oxycodone 5 mg (milligrams) to be administered every 4 hours for pain rated 1 to 5 (on scale with zero as no pain, 10 as worst pain). The record also documented a physician's order dated 12/25/17 for Oxycodone 10 mg to be administered every 4 hours as needed for pain rated 6 to 10.

Resident #20's medication administration record (MAR) documented as needed Oxycodone was administered on the following dates/times:

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1/2/18 at 3:20 a.m.
1/2/18 at 8:03 p.m.
1/3/18 at 6:33 a.m.
1/6/18 at 11:54 a.m.
1/7/18 at 10:37 p.m.
1/8/18 at 5:14 p.m.
1/12/18 at 12:19 p.m.
1/16/18 at 2:03 a.m.
1/16/18 at 5:50 p.m.

There were no documented assessments for these doses of Oxycodone indicating the location or type of pain. No pain rating from the pain scale of zero through 10 was documented for doses given on 1/3/18, 1/12/18 and 1/16/18. There were no attempts of any non-pharmacological interventions for pain reduction listed for any of these as needed doses of Oxycodone.

Resident #20's plan of care (revised 1/10/18) listed the resident was at risk for pain due to left hip surgery. Interventions to minimize pain included medications, repositioning with pillows for comfort, ice pack with towel barrier and, "Observe/report/document probable cause of pain episode. Minimize/limit cause when possible..."

On 1/17/18 at 8:57 a.m., the licensed practical nurse (LPN #1) caring for Resident #20 was interviewed about pain assessments associated with the Oxycodone administration. LPN #1 stated the notes listed in the clinical record were automatically entered from the MAR system when the medication was administered. LPN #1 stated there was space in the MAR system to enter custom notes about the location, pain rating and any non-drug interventions. LPN #1 stated

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(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
F 697	Continued From page 13	F 697		

Resident #20 did not like ice but was offered leg elevation and repositioning to minimize pain. LPN #1 stated the pain location, pain rating and type of pain should be entered in the record when the as needed pain medication was given.

On 1/17/18 at 2:14 p.m., the director of nursing (DON) was interviewed about assessments for pain and non-drug interventions. The DON stated nurses were supposed to enter a note in the clinical record indicating the location, type of pain and a pain rating when as needed pain medication was administered. The DON stated their MAR system provided a space for customized notes. The DON stated any non-drug interventions offered or attempted should also be documented in the clinical record.

The facility's policy titled Pain Management Program stated concerning administration of as needed (prn) pain medication, "When analgesic medication is administered in response to an episode of pain, the licensed nurse or Medication Care Manager documents the evaluation, treatment, and the effectiveness of the treatment... The following is documented: Date and time... Pain rating...Non-pharmacological treatments provided... Location of pain... Medication name and dose... Administering nurse..."

The Nursing 2017 Drug Handbook on page 1102 describes Oxycodone as an opioid analgesic used for the management of moderate to severe pain. This reference states on page 1105 Oxycodone has a black box warning and all patients on opioids should be routinely monitored for signs and symptoms of misuse, abuse and addiction. Adverse effects include respiratory

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	495254	A. BUILDING _____ B. WING _____	C 01/18/2018

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COLONNADES HEALTH CARE CENTER	100 COLONNADES HILL DRIVE CHARLOTTESVILLE, VA 22901

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F 697	Continued From page 14 depression and dizziness. (1) These findings were reviewed with the administrator and director of nursing during a meeting on 1/17/18 at 4:45 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 697		
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, facility document review and staff interview, the facility staff failed to store, prepare and distribute food in a sanitary manner. Expired food items were available for use in the pantry refrigerator. Foods were not held and/or	F 812		

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F 812	Continued From page 15	F 812		

reheated at the proper temperature on the steam table in the pantry kitchen. Dietary staff failed to follow proper hand washing during food preparation and service in the pantry kitchen. Undated and improperly sealed food items were stored in the nourishment refrigerator on the residents' living unit.

The findings include:

a) Expired food items were available for use in the pantry refrigerator. Foods were not held and/or reheated at the proper temperature on the steam table in the pantry kitchen. Dietary staff failed to follow proper hand washing during food preparation and service in the pantry kitchen.

Lunch service from the pantry kitchen was observed on 1/16/18 starting at 12:00 p.m. Stored in the pantry refrigerator was a container of fresh orange slices and parsley labeled with a discard date of 1/15/18. An opened loaf of bread was also stored in the refrigerator with a discard date of 1/15/18.

On 1/16/18 at 12:06 p.m., a dietary employee was interviewed about the out of date items. The employee stated the items were "just garnish" and stated he would discard them today. The dietary employee moved the garbage can by hand near the refrigerator and discarded multiple out of date items. Without washing his hands, this employee put on gloves and proceeded to removed clean bowls from the cabinet for lunch service. Improper hand washing was also observed with another dietary employee during the lunch service. This employee washed his hands at the sink and turned off the water by directly touching the faucet handles prior to drying

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F 812	Continued From page 16	F 812		

his hands. This was observed on 1/16/18 at 12:24 p.m. and 12:36 p.m.

A dietary employee measured temperatures of food items on the steam table on 1/16/18 at 12:22 p.m. The pureed zucchini was 132 degrees (F) and the pureed meat loaf was 132 degrees (F). The zucchini was sent back to the kitchen for reheating. On 1/16/18 at 12:44 p.m. the zucchini was returned to the steam table measuring 163 degrees. The pureed meat loaf was not returned to the kitchen for reheating. The dietary employees proceeded to serve multiple servings of pureed zucchini and five servings of the pureed meat loaf. On 1/16/18 at 12:56 p.m., a recheck of the pureed meat loaf temperature indicated 134 degrees. The dietary worker stated at this time the meat loaf had not been sent back to the kitchen for reheating.

On 1/16/18 at 12:22 p.m., the dietary employee checking food temperatures was interviewed about required food temperatures. The employee stated foods under 140 degrees were supposed to be sent back to the kitchen for reheating. On 1/16/18 at 4:00 p.m., the executive chef was interviewed about the food temperatures. The chef stated reheated foods were supposed to reach 165 degrees prior to service. The chef stated he was not thinking of the pureed zucchini as a reheat. The chef stated the pureed meat loaf was not returned to the kitchen for reheating.

On 1/16/18 at 4:15 p.m., the dietary manager was interviewed about the food temperatures, out dated refrigerated items and improper hand washing. The dietary manager stated foods on the steam table were supposed to be held at 140 degrees or higher. The dietary manager stated

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F 812	Continued From page 17	F 812		

food found below 140 degrees was sent back to the kitchen for reheating. The dietary manager stated reheated foods were supposed to reach 165 degrees prior to serving. Concerning hand washing, the dietary manager stated employees were supposed to wash their hands between tasks, especially when handling something dirty. The dietary manager stated employees were supposed to turn off the water using a clean paper towel and were not to touch the faucet handle directly with clean hands. The dietary manager stated expired food items were supposed to be discarded daily.

The facility's policy titled Service Temperature of Food (2014) documented, "...If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to the proper temperature or if it cannot be corrected in time for meal service make an appropriate menu substitution...Acceptable serving temperatures are...Pureed food, hot 140 [degrees] - 165 [degrees]...Meat, entrees 140 [degrees] - 165 [degrees]...If temperatures do not meet acceptable serving temperatures, reheat product to 165 [degrees]..."

The facility's policy titled Handwashing (revised 9/15/99) stated, "Team members thoroughly wash their hands to prevent the spread of infection to patients, team members, and visitors...Use paper towels to turn off faucet, then discard the towel in the proper receptacle... Hands must be washed...Before and after handling food..."

The facility's policy titled Labeling & Dating Standards (2015) stated, "...Use 'Use-by-dates' on all food once opened and stored under refrigeration...Leftover foods should not be saved

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F 812	Continued From page 18	F 812		

and re-used for human consumption if there is any doubt of wholesome quality..."

These findings were reviewed with the administrator and director of nursing during a meeting on 1/17/18 at 4:45 p.m.

b) Undated and improperly sealed food items were stored in the nourishment refrigerator on the residents' living unit.

On 1/17/18 at 9:18 a.m., the nourishment refrigerator on the living unit was inspected. The interior of the refrigerator had an unpleasant odor. A Ziploc back of some type of rice mixture was stored in the bottom drawer. The bag had no date and did not identify the food product. The bag was leaking with liquid from the bag in the bottom of the drawer and on prepackaged juice containers also stored in the drawer. A dried substance was on the bottom of the refrigerator under the drawer. A dried, dirty substance was also noted on the floor below the refrigerator. A bowl of some type of chocolate food was in the freezer loosely covered with aluminum foil. This bowl was undated and unidentified. A clear plastic container of an ice cream dessert was also stored in the freezer with no date and/or identifier.

On 1/17/18 at 9:20 a.m., the registered nurse (RN #1) working on the living unit was shown the refrigerator and interviewed about the improperly stored food items. RN #1 stated the rice mixture in the Ziploc bag was possibly saved to feed for the facility's dog. RN #1 stated the undated items should have been discarded. RN #1 stated the night shift nurses were responsible for checking the refrigerator daily and discarding any needed

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F 812	Continued From page 19 items. The facility's policy titled Labeling & Dating Standards (2015) stated, "...Use 'Use-by-dates' on all food once opened and stored under refrigeration... Store food in approved food storage containers... When food is taken out of an original container write the name of the food being stored on the container and the use by date... Leftover foods should not be saved and re-used for human consumption if there is any doubt of wholesome quality..." These findings were reviewed with the administrator and director of nursing during a meeting on 1/17/18 at 4:45 p.m.	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a dishwasher was in proper working order. The wash temperature gauge on the dishwasher in the main kitchen was not functioning properly. The findings include: On 1/16/18 at 10:30 a.m., the dishwasher in the main kitchen was observed. During multiple runs of the dishwasher, the wash temperature gauge displayed temperatures between 115 degrees (F) and 120 degrees (F). The dietary employee washing the dishes was interviewed at this time	F 908		

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F 908	Continued From page 20	F 908		

about the gauge. The dietary worker stated the wash temperature was supposed to be at least 120 degrees during the wash cycle. This employee stated they had experienced problems in the last couple of weeks with the gauge not indicating the required temperature. The employee stated actual checks of the water temperature with a thermometer indicated readings above 120 degrees. The dietary worker performed an actual check of the wash water temperature with the temperature reading 122.6 degrees.

On 1/16/18 at 4:00 p.m., the executive chef was interviewed about the wash temperature gauge on the dishwasher. The chef stated maintenance had worked on the gauge in the last week. When asked if the gauge was working properly, the chef stated he would check with maintenance about the status of the gauge.

On 1/18/18 at 9:15 a.m., the director of food/beverage services was interviewed about the dishwasher gauge. The food/beverage director stated maintenance checked the gauge again and found the gauge reading approximately 7 degrees below the actual water temperature. The food/beverage director stated he was not aware of the continued problem with the gauge. The food/beverage director stated the gauge was not functioning properly and would be replaced.

These findings were reviewed with the administrator and director of nursing during a meeting on 1/18/17 at 11:45 a.m.

Paul.

Sunrise Senior Living
Skilled Nursing Plan of Correction Template

Name of Community:	**The Colonnades**
Medicare or License Number:	**495254**
Survey Date(s):	**1/16/18-1/18/18**
Name and Title of Representative Signing the Plan of Correction:	**Jennifer Crouch, Licensed Nursing Home Administrator**
Signature of Representative:	Jf Crouch, LNHA
Submission Date to Regulatory Agency:	2/2/18

Per CMS, a Skilled Nursing Community may submit their POC as a separate document attachment or document the POC on the right side of CMS Form 2567.

Regulation	Target Date By Which Correction Will Be Completed	Plan of Correction
F655 Baseline Care Plan	2/2/18	**A. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:** R276 is a closed record and therefore cannot be amended Director of Nursing (DNS) and Designees conducted an audit on 1/29/18 of residents admitted from 1/18/18-1/29/18 to confirm base line care plans were developed within 48 hours of a resident's admission and included the necessary healthcare information to care for a resident and to confirm cognitive impairment needs and ambulation status were addressed. Care plans were updated as needed. An audit of care plans was conducted by the DNS or designee of residents admitted 1/18/18-1/29/18 coded under Section G (functional status as needing physical assistance with locomotion on and off the unit) and care plans were updated as needed. Nursing staff refresher education was initiated by the DNS on 1/29/18 regarding including supporting documentation for resident diagnoses.

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Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

		B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: New admission baseline care plans will be reviewed in daily morning clinical meetings to confirm that we have the necessary healthcare information to provide care for a resident. The Nurses will review the care plan with the resident and/or representative within 48 hours of admission and document the meeting. Director of Nursing/Designee conducted refresher trainer on 1/29/18 for the Nurses on developing and implementing a base line care plan on each new resident. Also a refresher training session was initiated by the DNS or designee on 1/29/18 for the Nurses regarding the process of reviewing baseline care plan within 48 hours with the resident and/or representative and documenting a care plan note in the resident record. A refresher training session was conducted on 1/30/18 by the DNS or designee regarding the process for completing the nursing sections of an admission assessment.
		C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: In order to confirm that the processes outlined above are sustained: an audit of new admissions will be conducted daily to confirm baseline care plans were completed within 48 hours of admission. The audit will be conducted daily for 4 weeks and then weekly for 2 months. The audit results will be reviewed during our monthly QAPI meeting for 3 months. During and at the conclusion of each month, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.

		D. The title of the person responsible for implementing the acceptable plan of correction (not the name): The Director or Nursing Services/Designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction and addressing and resolving variances that may occur.
Regulation	**Target Date By Which Correction Will Be Completed**	**Plan of Correction**
F689 Free of Accident Hazards/Supervision/Devices	2/2/18	**A. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:** R276 is a closed record and cannot be amended. Four audits were conducted: An audit of care plans was completed on 1/29/18 by the DNS or designee of residents with a cognitive impairment and currently on Speech Therapy caseload to confirm that the care plans addressed cognitive, fall risk, and mobility needs as determined through nursing assessment and therapy evaluation. An audit was completed on 1/31/18 by the DNS or designee to confirm that the care plans include interventions to manage falls risk based on cognitive and mobility needs. An audit was completed by the DNS and RAC on 1/29/18 of care plans for residents coded for cognitive impairment to confirm that their ambulation needs and corresponding interventions, based on their cognitive capacity, were addressed in the care plan. In addition, the DNS or designee audited residents admitted 1/18/18-1/29/18 coded under Section G (functional status as needing physical assistance with locomotion on and off the unit) to confirm the specific needs and corresponding interventions were captured in the care plan. Care plans were updated if needed.

		Based on the four audits conducted, care plans including interventions were updated, if needed, for cognitive status, fall risk, and ambulation needs. Resident mobility devices were screened to confirm appropriateness based on the mobility needs of the resident by a Physical Therapist on 1/30/18. Care plans were updated if needed. Resident mobility devices were screened to confirm appropriateness, based on the mobility needs of the resident, by a Physical Therapist on 1/30/18. Care plans were updated if needed.
		B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Changes in resident condition regarding fall risk status, cognitive status, resident safety awareness, and mobility needs and devices will be discussed in the daily clinical meeting and Interdisciplinary Meetings and care plans are corresponding interventions will be updated accordingly. The Care Team will be alerted by DNS or designee of resident changes in condition and care plan updates through special instructions in the resident headers in the resident's electronic clinical record and during shift crossover meetings. Refresher education was initiated for the Nurses and CNAs on 1/23/18 by the DNS and/or ADNS to include documenting resident safety choices and notifying the MD/RP and the DNS/ADNS of such choices. On 1/23/18 a refresher training session was initiated by the DNS or designee for Nurses and CNAs regarding residents who are exhibiting poor safety awareness, including staff responsibilities for confirming their safety, notifying the MD/RP and the DNS/ADNS of resident safety awareness issues, and documenting in the progress notes and updating in the care plan, if needed. The DNS or ADNS conducted a refresher training session on 1/23/18 with the Nurses regarding the process for updating care plans and interventions as resident changes in condition occur.

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		The DNS or designee conducted a refresher training session on 1/30/18 for the Nurses and CNAs on accessing special instructions in the resident header and reviewing the Kardex in the point of care at the care kiosk.
		C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: In order to confirm that the processes outlined above are sustained: We will audit the care plans of residents who experience a change in condition (mobility, cognitive status, assistive device, falls risk, safety awareness) to confirm that the care plan and corresponding interventions have been updated and have been communicated to the care plan. This audit will occur daily for 4 weeks and then weekly for 2 months and audit results will be reviewed during our monthly QAPI meeting for 3 months. During and at the conclusion of each month, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
		D. The title of the person responsible for implementing the acceptable plan of correction (not the name): The Director or Nursing Services/Designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction and addressing and resolving variances that may occur.
Regulation	**Target Date By Which Correction Will Be Completed**	**Plan of Correction**
F697 Pain Management	2/2/18	**A. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:** Resident #11: Was discharged to home per discharge plan. Pain medication order was in

		place with pain rating scale present. Care plan was in place including non-drug interventions for pain management. Resident #20: Was discharged to home per discharge plan. Pain medication orders were updated during the actual survey to reflect pain rating and location of pain. Care plan was in place including non-drug interventions for pain management. An audit of residents with PRN pain management orders was conducted on 1/29/18 by the ADNS to confirm non pharmacological interventions are in the care plan and the pain scale is included in the order. Care plans were updated if needed.
		B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The process for the Nurses documenting in the progress notes, the pain assessments, and the non-pharmacological interventions that are initiated has been enhanced to include a review of the pain related documentation during the daily clinical stand up meetings. On 1/29/18 a refresher training session was initiated on conducting pain assessments and corresponding documentation including the following: pain rating, location of pain, type of pain, and the non-pharmacological interventions utilized prior to administering PRN analgesic medication. DNS/designee conducted a refresher training session on 1/30/18 for the Nurses regarding pain related documentation in E-Mar progress notes and the path to directly access care plans from the E-MAR lap top and a refresher training session for the CNAs on accessing the Kardex to review pain management interventions.
		C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

		In order to confirm that the processes outlined above are sustained: The Medication Administration record and progress note of PRN analgesic medications will be audited by the DNS or designee to confirm documentation including pain rating, location, type, and non-pharmacological interventions utilized. This audit will occur daily for 4 weeks and then weekly for 2 months and the audit results will be reviewed during our monthly QAPI meeting for 3 months. During and at the conclusion of each month, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
		D. The title of the person responsible for implementing the acceptable plan of correction (not the name): The Director or Nursing Services/Designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction and addressing and resolving variances that may occur.
Regulation	**Target Date By Which Correction Will Be Completed**	**Plan of Correction**
F812 Food Procurement, Store/Prepare/Serve-Sanitary	2/2/18	**A. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:** The refrigerators in the skilled nursing kitchen and the refrigerator at the nursing station were cleaned and expired food items discarded on 1/16/18. The Certified Dietary Manager provided refresher training for the dietary team members on 1/24/18 regarding food safety, kitchen sanitation, disposing of expired food items, monitoring of appropriate food and equipment temperatures and handwashing during food preparation. The Certified Dietary Manager conducted walking rounds of the skilled nursing kitchen on 1/16/18. No food safety or kitchen sanitation issues were observed.

		B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The daily team member assignment sheet and oversight processes used by the CDM and dietary supervisors were reviewed and enhanced as needed, to include monitoring of expired food items, proper hand hygiene, disposing of expired food items, cleaning of refrigerators and other equipment, confirming proper temperature of food items and the required temperatures of refrigerators and other kitchen equipment. The Dining team members received refresher training by the CDM on 1/24/18 on their daily responsibilities for food safety and kitchen sanitation, including proper hand hygiene, proper serving temperature of food items, and monitoring of expired food items and using and completing the daily team member duty sheet. The Nursing team member's received refresher training conducted by the ADNS on 1/30/18 on their daily responsibilities for cleaning refrigerators and monitoring of food items to confirm they are dated and no expired. The orientation for new dining team members is being enhanced to include and emphasis on their daily responsibilities for food safety and kitchen sanitation, hand hygiene, serving temperature of food items, monitoring for and disposing of expired food items, and the daily team member duty sheet. Orientation will be conducted by the Certified Dietary Manager or Designee.
		C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: In order to confirm that the processes outlined above are sustained: The CDM or designee will conduct all audits and observations of cleaning checklists, food safety and kitchen sanitation, food expiration and dating, hand washing, and food and equipment temperatures.

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		These audits and observations will occur weekly for 3 months and the results will be reviewed during our monthly QAPI Meeting for 3 months. During and at the conclusion of each month, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
		D. The title of the person responsible for implementing the acceptable plan of correction (not the name): The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
Regulation	**Target Date By Which Correction Will Be Completed**	**Plan of Correction**
F908 Essential Equipment, Safe Operating Condition	2/2/18	**A. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:** The water temperature was immediately checked with the surveyor present and the water in dishwasher was at proper temperature. A new dishwasher gauge was ordered 1/18/18 by the maintenance department and installed on 1/22/18; however, the new gauge malfunctioned and a new gauge is expected to arrive and be installed on 2/2/18. In the interim, the dietary team is continuing to obtain daily dishwasher water temperatures and the temperatures. The temperatures continue to remain at the appropriate level.
		B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The dietary team is continuing to obtain daily dishwasher water temperatures and the temperatures remain at the appropriate level.

		Refresher training was provided to the dietary team by Administration and the CDM regarding notifying their immediate supervisor if daily checks reveal that the dishwasher gauge is not functioning and the necessity of continuing to obtain daily dishwasher water temperatures to confirm appropriate temperatures.
		C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: In order to confirm that the processes outlined above are sustained: The Dining Services Coordinator and/or the CDM will check the gauge and dishwasher temperatures daily for 2 weeks and then weekly for 2 and ½ months and the audits and checks of the gauge and water temperatures will be reported at the QAPI Meeting for 3 months. During and at the conclusion of each month, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
		D. The title of the person responsible for implementing the acceptable plan of correction (not the name): The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
Regulation	**Target Date By Which Correction Will Be Completed**	**Plan of Correction**
		A. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:
		B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited:

		C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:
		D. The title of the person responsible for implementing the acceptable plan of correction (not the name):
		If needed, please continue to add more rows incorporating the header and the language for A – D as delineated above

Quality Department 7/16/17

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.